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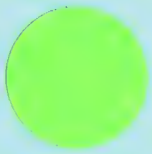


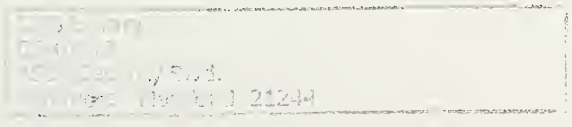
Data Compendium on Physicians and Other Non-institutional Suppliers

U.S. Department of Health and Human Services
Health Care Financing Administration
Bureau of Data Management and Strategy

Data Compendium on Physicians and Other Non-institutional Suppliers

Prepared by: The Division of Information Analysis
Office of Statistics and Data Management
Bureau of Data Management and Strategy

Spring 1989



INTRODUCTION

This Physician Compendium provides information on physicians and other non-institutional suppliers of goods and services. Included are data on trends in utilization of services, program expenditures, beneficiary liabilities, and the Medicare Provider Participation Program. Also included are data on procedures provided to Medicare participants, and other general information on physicians.

The Compendium is intended for use by the Health Care Financing Administration staff as a general information resource on Medicare physician and other non-institutional supplier activity.

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Section I

Sources and Limitations

Data for this compendium were derived from a variety of sources both internal and external to HCFA.

Section II

- SMI benefit cash flows are periodically estimated by HCFA's Office of the Actuary (OACT). It is important to note the distinction between benefit cash flows, as shown in Section I, Table 1, and benefit accrued amounts, shown in the following sections. Cash flows represent dollar amounts paid for SMI services in a time period regardless of the time period in which the service was provided. Accrued or incurred amounts represent program obligations for services provided in a given period of time, regardless of when the payment was actually made. Since dollar amounts on an accrued basis arrive in HCFA's central record system with a significantly longer lag period than dollar amounts on a cash flow basis, estimates of recent accrued benefit payments are more uncertain than estimates of cash flows. Estimates of accrued benefit amounts in this compendium are based on records available to the Bureau of Data Management and Strategy, HCFA.

- Person-use rates are derived from a sample of Medicare enrollees (5 percent of aged persons and 25 percent of disabled persons under age 65) reported in HCFA's Person Summary File. "Person-users" in this section are defined as persons who incur some SMI program payments.

- Inpatient hospital admissions were obtained from American Hospital Association (AHA) Panel Surveys, a monthly sample survey of community hospital activity. BDMS has established that Medicare aged and disabled inpatient activity is accurately portrayed by the AHA's Panel Category, "Persons Age 65 and Over". Since HCFA's internal sources on inpatient hospital activity are subject to significant reporting lags, and since they are affected by other reporting problems, recent Medicare inpatient trends are represented by AHA data in Table 7.

Section III

- All data in this section are for physicians and other

non-institutional suppliers of medical goods and services. No charge or utilization activity for institutional suppliers of medical good and services are included (i.e., charges by inpatient or outpatient hospital facilities, nursing homes, home health agencies, etc.).

Table 1

- HCFA maintains ongoing statistical tabulations, the Current Utilization (CU) Tables, which record program payments allocated to the year in which an expense was incurred based on payment records submitted by Part B carriers. The CU tables were the primary source of time series of program payments in Table 1.

  Prior to the implementation of the Prospective Payment System (PPS), hospitals could bill for the professional component of certain physician services (the "combined billing" procedure). The "combined bill" amounts were paid by Fiscal Intermediaries rather than Part B carriers and thus did not generate payment records. After PPS, payments for such physician services were made by Part B carriers. To ensure a consistent time series of program payments for fee-for-service physician and other non-institutional supplier payments, amounts for combined billings were obtained from HCFA's Office of the Actuary for pre-PPS years to supplement the CU payment record data. Other adjustments to the CU tabulations were made to account for amounts of payments which were previously erroneously reported by Part B carriers and to account for lags in data submission for recent time periods.

  The estimated time series for incurred program payments in Table 1 is generally consistent with other internal HCFA estimates but differs from them for some years primarily depending on data sources used.

- Balance billing amounts have been reported by Part B carriers to the Bureau of Program Operations (BPO) since 1975 in monthly workload reports and to the Bureau of Data Management and Strategy (BDMS) in annual submissions of Part B Medicare Annual Data (BMAD) statistical information since 1984. Both sources were used in Table 1.

- Part B coinsurance amounts for fee-for-service physician and other non-institutional suppliers of service were estimated from program payments. Generally, Part B coinsurance amounts are 20 percent of allowed charges after the $75 SMI deductible has been met. Certain services paid on a fee schedule do not require a coinsurance or deductible payment. Psychiatric services are subject to a 50 percent coinsurance rate after the SMI deductible is met.

- Part B deductibles attributable to users of physician and other non-institutional suppliers of Part B services are not directly measurable from any current available data source and thus were estimated in Table 1.

  Step (1) Deductibles for persons who incurred some SMI program payments were computed from HCFA's Person Summary File which is based on payment records submitted by Part B carrier.

  Step (2) Deductibles for persons who used outpatient hospital facilities but did not incur a physician/supplier payment were estimated from the Person Summary File were subtracted from (1).

  Step (3) An amount for deductibles incurred in outpatient hospital facilities was estimated from available hospital cost reports (generally less than 20 percent of total SMI deductible obligations). Deductible amounts estimated in (2) were subtracted from total outpatient facility deductible amounts. The remainder was subtracted for (1).

  Step (4) SMI deductibles for persons who did not incur SMI program payments were determined by, first, estimating the number of persons who had some covered physician service (household surveys indicate that about 80 percent of Medicare enrollees incur at least one covered service in a year; second, subtracting the number of persons who incurred some SMI program reimbursements (available from HCFA's Person Summary File); and third, multiplying the number of persons who used

some service but did not meet the deductible by half of the applicable deductible. (Annual deductible amounts were $50 from 1966 through 1971, $60 from 1971 through 1981, and $75 since 1982.)

- Liabilities from all sources (balance billings, program payments, coinsurance and deductibles were summed to obtain total incurred liabilities for all fee-for-service physician and non-institutional supplier Medicare covered services.

- Patient liabilities for balance billing, coinsurance and deductibles represented in this section are "potential" liabilities, not "actual" liabilities. Information on liability amounts actually collected from patients is not available.

Tables 5 and 6

- Data on general economic and national health and physician/durable medical equipment (DME) expenditure trends were provided by the Office of National Cost Estimates, OACT.

Table 7 through Table 14

- Data for ambulatory surgical centers are included in "outpatient hospital" place of service in all tables. "Other" place of service in all tables includes home, independent laboratory, nursing home, limited care facility and unknown place of service.

- Data on the distribution of allowed charges by place and by type of service in Table 7 were derived from the BMAD Procedure Master File (all records), a 100 percent sample file, for 1985 through 1987 and from the Part B Bill Summary Record for 1975 through 1984. The Physician Summary Record, a 5 percent sample of bills submitted to Part B carriers, contained information from 1490 and 1500 billing forms but omitted billings by institutions on behalf of physicians to Part B carriers (the "1554" billing procedure) and "combined" billings to Fiscal Intermediaries on 1453 and 1483 billing forms for the professional component charges of hospital-based physicians. Estimates for omitted 1554 billings were made from Part B payment records for inclusion in this section.

Quantitative data on "combined" billings by place and by type of service was not available from any source. Total combined billings were allocated to place and to type of service on the basis of consultation with policy specialists.

- Two changes in Medicare affect the scope of non-physician services billed by physicians and, therefore, trends in billings by type and by place of service in this section. First, prior to October 1, 1983 non-physician services and suppliers furnished to Medicare inpatient such as laboratory tests, pacemakers, and intraocular lenses, could be billed by physicians or other providers whether or not they provided them directly. However, the "rebundling" provision of the prospective payment system (PPS) prohibited physicians from billing Medicare inpatients separately for non-physician services because they are covered in the prospective payment amount. Second, clinical laboratory services provided and/or billed by physicians prior to July 1984 includes some services billed by physicians but not furnished by them directly. Beginning in July 1984, physicians were prohibited from billing for laboratory tests which they did not provide themselves. These policy changes introduced discontinuities in trends by place of service in Table 7.

- Since the source of approved charge distribution by place and by type of service in Table 7 changed from 1984 (the Physician Summary Record) to 1985 (the BMAD Procedure Master Record), discontinuities in definitions may have been introduced which affect results shown in the table.

- Data in Tables 11 through 15 were obtained from the BMAD Procedure Master File (all records) for 1987. Although all Part B carriers submitted this file in 1987, the accuracy of some data elements is suspect and is still being investigated.

- At the recommendation of HCFA persons who work with the source of this information, the Annual BMAD Procedure File for six carriers have been omitted from the computations in Tables 11 and 12. The six are Health Care Service Corporation (Illinois),

Blue Cross and Blue Shield of Michigan, Rocky Mountain Hospital and Medical Service (Colorado), Blue Cross and Blue Shield of Kansas, Inc., Wisconsin Physicians Service Insurance Corporation, and Prudential Life Insurance Company (New Jersey).

Section IV

All data in this section were derived from periodic reports by Part B carriers to the Bureau of Program Operations, HCFA.

Section V

Data in this section were derived from the BMAD statistical submission for 1987. No adjustments for missing data have been made in these data. Procedures are displayed in accordance with the HCFA Common Procedure Coding System (HCPCS). HCPCS defines procedures on three levels:

- Level (1) Physician Current Procedural Terminology (CPT) codes defined by the American Medical Association. These codes are all numeric.

- Level (2) HCFA codes for physician and non-physician services that are not contained in CPT-4. These are alpha-numeric codes used to process services such as ambulance, durable medical equipment, orthotics and prosthetics, etc.

- Level (3) Carrier or State agency assigned codes for services that are not contained in the first two levels but are needed to process Medicare and Medicaid claims. These are alpha-numeric codes that begin with W, X, Y or Z. Detailed data for these codes have been omitted from all tables in this section.

- The number of services and average charge per service for certain procedures in Table 6 have been omitted because definitions of units of service for many of the procedures are uncertain.

- Procedure data in Table 1 includes all types of service associated with a particular procedure code. For example, procedure code 66984, Remove Cataract, Insert Lens, includes any surgical charge, anesthesia charge, assistant-at-surgery

charge, etc., which may have been reported under code 66984. In Tables 2 through 6, charges for a particular procedure code have been disaggregated into place of service and type of service.

Section VI

Data for Table 1 were derived from the BMAD Procedure Master File. Data for Table 2 were derived from the BMAD Beneficiary File. Data for Table 3 were derived from the BMAD Five Percent Provider File. Data for Table 4 were derived from payment records submitted to HCFA. Adjustments for missing data have been made in Table 1, but not in Tables 3 and 4.

It has been determined that the BMAD Five Percent Provider File is not exactly a representative file for the universe of providers submitting bills to Part B carriers. Further, the definitions of provider specialty in the BMAD Five Percent Provider File differ in some instances from the definitions in the BMAD Procedure Master File and from the definitions for the payment record files. Therefore, the dollar amounts and rankings shown by specialty in Table 3 differ from amounts shown in other tables.

Section VII

Annual estimates of historical and projected physician census trends are made by the Bureau of Health Professions, Health Resources and Services Administration, and the Bureau of the Census. Annual estimates of physician income and expenses are made from a sample survey conducted by the American Medical Association.

Acknowledgment: The Division of Information Analysis, BDMS, thanks a number of HCFA components for their support in preparation of this compendium, particularly the Division of Reports and Analysis, Bureau of Program Operations, the Division of Program Studies, Office of Research and Demonstrations, and the Office of National Cost Estimates, Office of the Actuary.

Section II

Supplementary Medical Insurance (SMI) Benefit Payments, Utilization and Related Trends

- Supplementary Medical Insurance benefits are paid for services provided by physicians and other non-institutional suppliers of medical goods and services, outpatient hospital and other outpatient facilities, alternative payment systems (HMOs, GPPPs, etc.) and, for persons not enrolled for Hospital Insurance (HI), home health agency services.

- The relative shares of SMI benefits of each of the four major suppliers of care has changed over time (Table 1). Generally, shares of payments to outpatient facilities have grown since Medicare began. In 1967, only 2.2 percent of all SMI cash disbursements were for outpatient facility care, a share which grew to nearly 20 percent in recent years. The shares of alternative payments systems, which had been stable in earlier periods, have grown steadily since the early 1980's. By 1987, 4.4 percent of all cash disbursements went to alternative payment systems. In 1987 the cash flow for SMI program payments for physician and supplier services portrayed in Table 1 increased nearly 18 percent over 1986 levels, a rate of increase which apparently slowed to about 13 percent in 1988.

- Recent trends in utilization are marked by decreasing inpatient hospital use rates and by increasing joint use of outpatient facilities and physicians (Table 2, Figure 1). In 1983, nearly 23 percent of all SMI enrollees used at least one inpatient hospital day of care. By 1986, the proportion had declined to 19 percent. However, early indicators point to a reversal of this trend in 1987 and an accelerated increase in inpatient hospitalization rates in 1988. The proportion of SMI enrollees who use both outpatient facilities and physician services increased both for patients who also used inpatient facilities and for those who did not (Table 3).

- The recent decline in the number of Medicare persons hospitalized was accompanied by other significant changes in inpatient hospital care which, as demonstrated in a following section, are manifested in changes in physician use and charge patterns. Inpatient discharges may be categorized into "surgical" or

"medical" discharges. While surgical discharges continued a long-term increase through 1984, medical discharges, reversing a long running trend, decreased in 1984 (Table 4). In 1985 and 1986, surgical discharges decreased primarily due to a decline in discharges for eye conditions. After 1983, medical discharges generally decreased in all major disease categories.

- Total short-stay inpatient hospital days of care declined rapidly after 1983 (Table 5). However, days of care for medical discharges declined much more rapidly than those for surgical discharges (which began to decline after 1984). The decrease in total days of care was accompanied by a relative increase in intensive inpatient hospital care (Table 6, Figure 2). Days of care in intensive care and coronary care units increased as total days decreased.

- Medicare community hospital inpatient admissions and inpatient days of care, which steadily declined after 1983, resumed a historical increase in late 1987. In 1988, inpatient admissions increased over 2 percent above 1987 levels (Table 7). (The source of these data, the American Hospital Association, characterizes the data as admissions for "persons age 65 and over". However, the data actually represents all Medicare admissions for Medicare aged and disabled enrolled persons.)

Table 1
Medicare Supplementary Medical Insurance (SMI) benefit cash disbursement:
Calendar years 1967 to 1987 1/

	1987	1986	1985	1984	1983	1975	1970	1967
				Dollars in millions				
Total	$30,820	$26,239	$22,947	$19,661	$18,106	$4,273	$1,975	$1,197
Physicians and suppliers 2/	23,503	19,937	17,869	15,715	14,287	3,454	1,801	1,135
Outpatient facilities 3/	5,903	5,144	4,304	3,450	3,387	652	117	26
Alternative payment systems 4/	1,361	1,113	720	464	410	80	26	19
Home health agencies	53	45	54	32	32	87	31	17
				Percent distribution				
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Physicians and suppliers 2/	76.2	76.0	77.9	79.9	78.9	80.8	91.2	94.8
Outpatient facilities 3/	19.2	19.6	18.8	17.5	17.2	15.3	5.9	2.2
Alternative payment systems 4/	4.4	4.2	3.1	2.4	2.1	1.9	1.3	1.6
Home health agencies	0.2	0.2	0.2	0.2	0.1	0.7	1.6	1.4

1/ Preliminary estimates, subject to revision.
2/ Includes independent labs.
3/ Includes outpatient hospital facilities, ESRD free-standing facilities, rural health clinics, and outpatient rehabilitation facilities.
4/ Includes health maintenance organizations, competitive medical plans and other pre-paid health plans.

Source: HCFA, OACT

Table 2
Medicare percent distribution of Supplementary Medical Insurance (SMI) enrollees by type of SMI benefit received and by hospitalization status: Calendar years 1983 to 1986

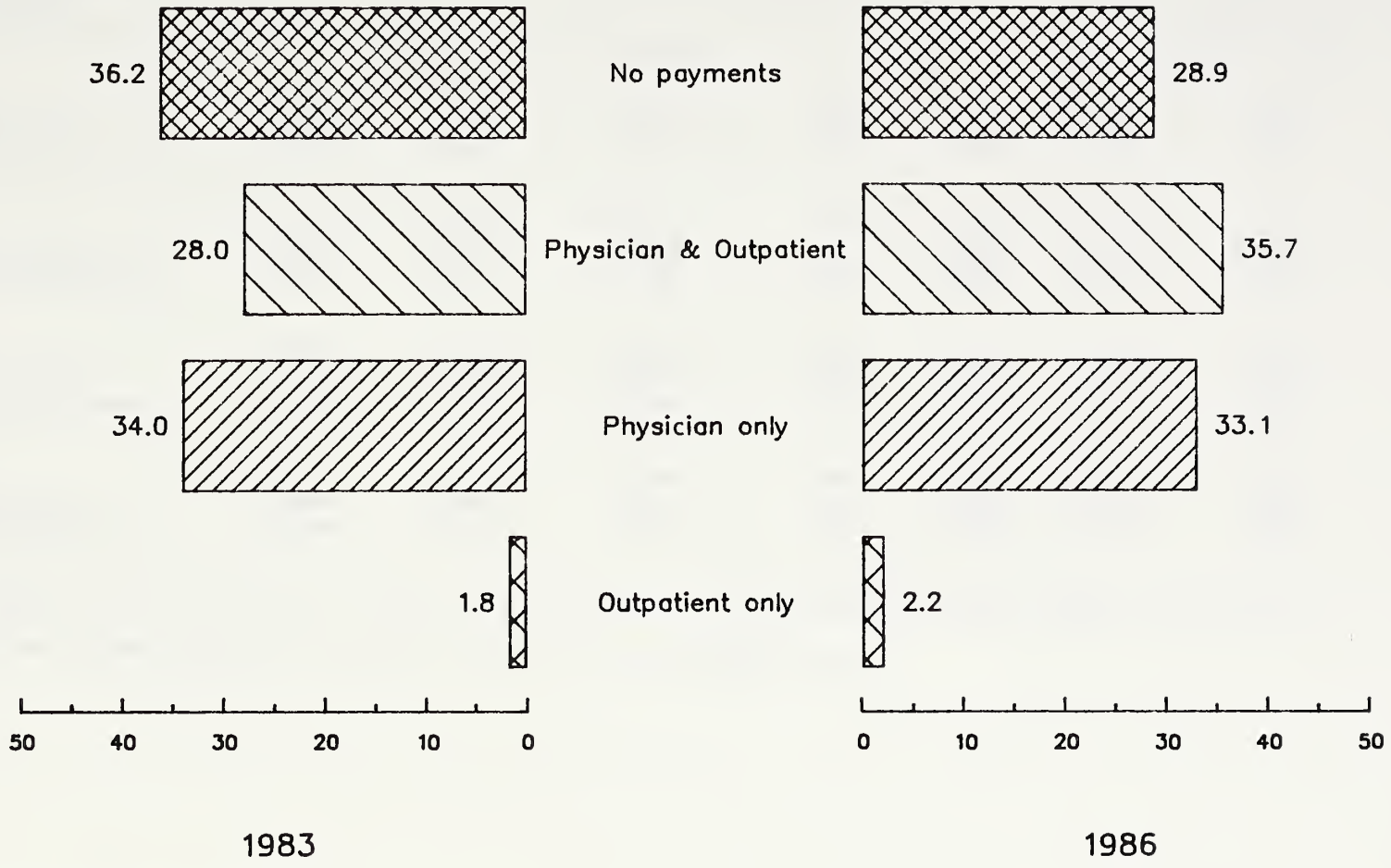
Hospitalization status	Total	Without benefit	With benefit			
			Total	Physicians only	Physicians and outpatient	Outpatient only
			Percent distribution			
1986						
Total	100.0%	28.9%	71.1%	33.1%	35.7%	2.2%
Hospitalized			19.2	6.3	12.8	0.2
Not hospitalized			51.8	26.8	22.9	2.0
1985						
Total	100.0	30.1	69.9	34.6	33.2	2.2
Hospitalized			19.6	6.8	12.6	0.2
Not hospitalized			50.3	27.8	20.5	2.0
1984						
Total	100.0	33.4	66.6	34.9	29.5	2.2
Hospitalized			21.8	9.2	12.4	0.2
Not hospitalized			44.7	25.7	17.1	2.0
1983						
Total	100.0	36.2	63.8	34.0	28.0	1.8
Hospitalized			22.8	10.4	12.3	0.2
Not hospitalized			41.0	23.7	15.7	1.6

NOTE: "Physicians" includes both physician and non-physician suppliers of medical goods and services.

Persons ever enrolled for SMI (in thousands): 1986 32,240
1985 31,605
1984 30,981
1983 30,508

SOURCE: HCFA, BDMS, Medicare Statistical System, Person Summary File.

Figure 1
Percent distribution of Medicare SMI enrollees, by type of benefit, 1983 and 1986



Prepared by Division of Information Analysis

Table 3
Medicare persons receiving Supplementary Medical Insurance (SMI) benefits for physicians/suppliers and for outpatient facility care, by hospitalization status of recipient: Calendar years 1983 to 1986

Hospitalization status	Type of benefit received				Type of benefit received			
	Total	Physicians only	Physicians and outpatient	Outpatient only	Total	Physicians only	Physicians and outpatient	Outpatient only
	Numbers in thousands				Percent distribution			
1986								
Total	22,907	10,685	11,520	703	100.0%	46.6%	50.3%	3.1%
Hospitalized	6,205	2,033	4,121	52	100.0	32.8	66.4	0.8
Not hospitalized	16,702	8,652	7,399	651	100.0	51.8	44.3	3.9
1985								
Total	22,102	10,929	10,481	692	100.0	49.4	47.4	3.1
Hospitalized	6,200	2,157	3,995	48	100.0	34.8	64.4	0.8
Not hospitalized	15,901	8,772	6,486	644	100.0	55.2	40.8	4.1
1984								
Total	20,632	10,822	9,138	672	100.0	52.5	44.3	3.2
Hospitalized	6,769	2,864	3,841	64	100.0	42.3	56.7	0.9
Not hospitalized	13,863	7,958	5,296	608	100.0	57.4	38.2	4.4
1983								
Total	19,471	10,383	8,540	548	100.0	53.3	43.9	2.8
Hospitalized	6,967	3,165	3,749	52	100.0	45.4	53.8	0.7
Not hospitalized	12,504	7,218	4,791	496	100.0	57.7	38.3	3.9

NOTE: "Physicians" includes both physician and non-physician suppliers of medical goods and services.

SOURCE: HCFA, BDMS, Medicare Statistical System, Person Summary File.

Table 4
Medicare number of short-stay discharges by DRG surgical status and by major diagnostic category: Calendar Years 1983 to 1986

Major Diagnostic Category	1986	1985	1984	1983 1/
	Numbers in thousands			
Total discharges	10,345	10,728	11,433	11,720
Surgical	2,726	2,783	3,046	2,849
Medical	7,619	7,945	8,387	8,871
Surgical	2,726	2,783	3,046	2,849
Eye	119	180	464	--
Circulatory	397	367	343	--
Digestive	466	480	494	--
Musculoskeletal	528	533	526	--
Reproductive (male/female)	365	368	371	--
Kidney and urinary	177	182	183	--
Ear, nose, throat	43	46	51	--
Skin	137	142	147	--
Respiratory	48	47	45	--
Nervous	102	111	116	--
All other	344	327	306	--
Medical	7,619	7,945	8,387	8,871
Eye	17	21	30	--
Circulatory	2,152	2,192	2,217	--
Digestive	763	820	925	--
Musculoskeletal	433	482	561	--
Reproductive (male/female)	62	74	102	--
Kidney and urinary	336	337	364	--
Ear, nose, throat	97	108	131	--
Skin	158	167	195	--
Respiratory	1,229	1,275	1,273	--
Nervous	775	812	844	--
Hepatobiliary	163	173	191	--
All other	1,434	1,484	1,554	--

1/ Surgical data estimated for 1983 from incomplete DRG information. Accurate data by DRG disease category not available.

SOURCE: HCFA, BDMS, Medicare Statistical System, MEDPAR file.

Table 5
Medicare short-stay hospital days of care by surgical DRG status:
Calendar years 1983 to 1986

Days of care by type of stay	1986		1985		1984		1983	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
	Numbers in millions							
All stays	90.0	100.0%	92.3	100.0%	101.8	100.0%	114.9	100.0%
Surgical stays	29.4	32.7	28.7	31.1	30.8	30.3	27.9	24.3
Medical stays	60.6	67.3	63.6	68.9	71.0	69.7	87.0	75.7

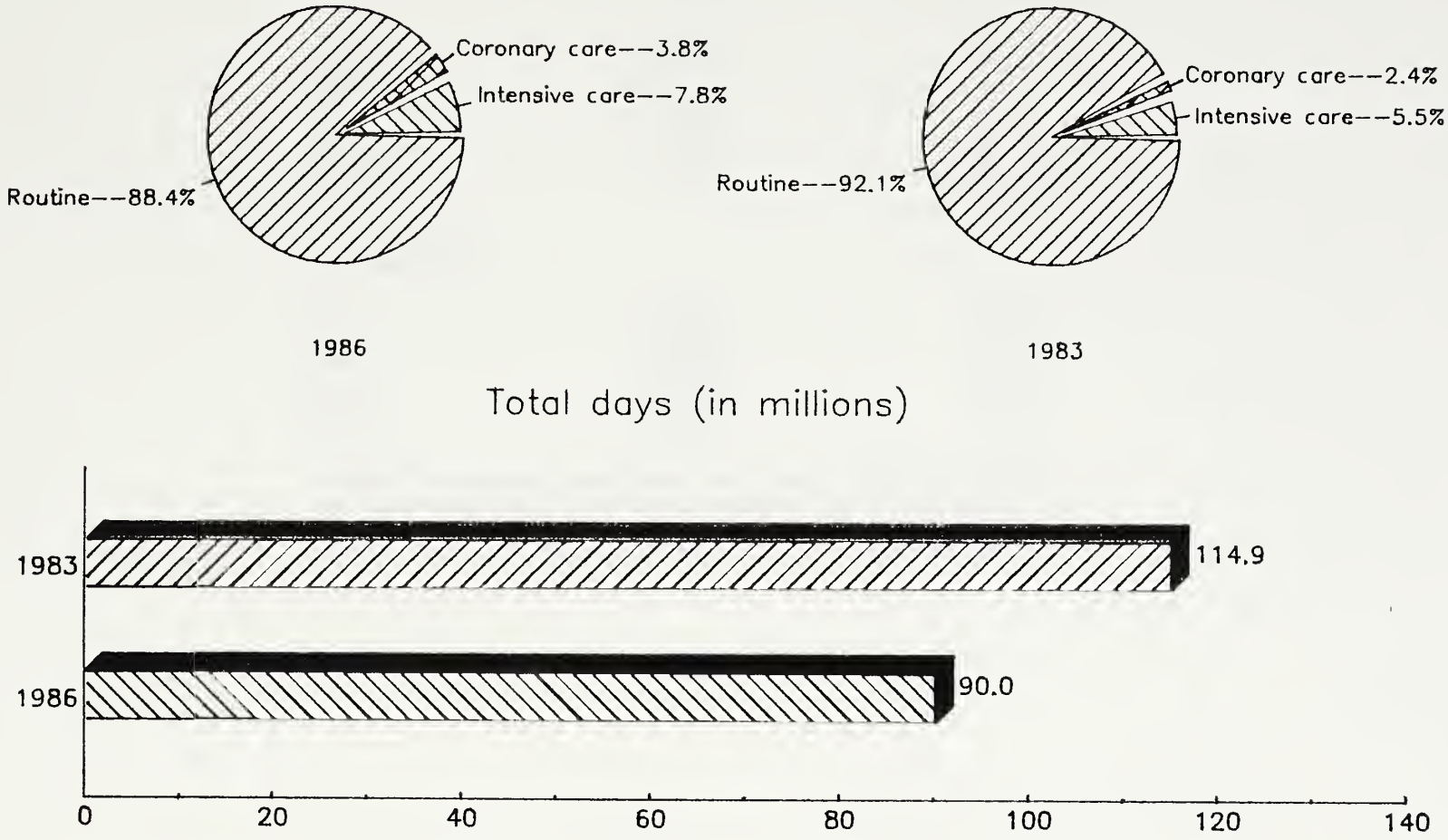
SOURCE: HCFA, BDMS, Medicare Statistical System, MEDPAR file.

Table 6
Number of days of Medicare short-stay hospital inpatient care by type of accommodation: Selected calendar years 1983 to 1986

Type of accommodation	1986		1985		1983	
	Number	Percent	Number	Percent	Number	Percent
	Numbers in millions					
All days	90.0	100.0%	92.3	100.0%	114.9	100.0%
Routine care days	79.6	88.4	82.4	89.3	105.8	92.1
Non-routine care days	10.4	11.6	9.9	10.7	9.1	7.9
Intensive care days	7.0	7.8	6.8	7.4	6.3	5.5
Coronary care days	3.4	3.8	3.1	3.3	2.8	2.4

SOURCE: HCFA, BDMS, Medicare Statistical System, MEDPAR file.

Figure 2
Short-stay hospital days of care by type of accomodation, selected years



Prepared by Division of Information Analysis

Table 7
Community inpatient hospital admissions and
days of care for persons age 65 and over:
Fiscal years 1982 to 1988 and
calendar years 1982 to 1987 1/

Years ending September 30	Admissions	Inpatient Days
	(in thous.)	(in millions)
1988	11,039	97.5
1987	10,778	95.8
1986	10,793	94.7
1985	11,011	96.5
1984	11,603	105.7
1983	11,793	115.7
1982	11,115	113.4
Years ending December 31		
1987	10,841	96.3
1986	10,795	94.9
1985	10,904	95.5
1984	11,508	103.0
1983	11,812	114.3
1982	11,278	114.2

1/ BDMS has determined that this data represent Medicare aged and disabled enrollees, and not just the aged.

SOURCE: American Hospital Association Panel Survey.

Section III

Fee-for-Service Physician and Other Non-institutional Supplier Charges and Utilization Trends

Background

- Services by physicians and other non-institutional suppliers generate potential payment liabilities that are shared by the Supplementary Medical Insurance (SMI) Trust Fund and the Medicare patients. Total liabilities are comprised of charges allowed by the Medicare program as "reasonable" charges and charges not allowed as "reasonable". Physicians who do not accept Medicare reasonable charge determinations as their final payment may bill patients for amounts exceeding "reasonable" charges (balance billings). Physicians who accept Medicare reasonable charge determinations may not bill patients for amounts exceeding reasonable charges. Allowed charges are comprised of amounts paid from the SMI Trust Fund (program payments) and patient liabilities (coinsurance and deductible amounts). Medicare coinsurance rates are 20 percent of allowed charges except for certain fixed fee services which require no coinsurance or deductible payments. Annual deductible amounts were $50 from 1966 through 1972, $60 from 1973 through 1981, and $75 from 1982 to the present.

  Data in this section are estimated to represent all fee-for-service physician and other non-institutional supplier billings, regardless of whether the claim was processed by or even submitted to a Part B carrier. Thus estimation was required for two situations: the billings for services of certain hospital-based physicians prior to fiscal year 1984, and the billings for physician/supplier covered services that are not submitted to Part B carriers. Institutional billings for medical goods and services (i.e., billings by inpatient hospitals, outpatient hospital facilities, nursing homes, home health agencies, etc.) are not included in this section.

  Since October 1983, all claims for services rendered by fee-for-service physicians and other non-institutional suppliers have been processed by Part B carriers. Prior to this date which is the implementation date for the inpatient hospital prospective payment system (PPS), the

services of certain hospital-based physicians were included in hospital bills processed by fiscal intermediaries (combined billing). A portion of the reimbursement on the institutional bill, therefore, represented a professional component. An adjustment was necessary for such billings through fiscal year 1983.

Claims for covered Medicare services are sometimes not submitted to Part B carriers because the annual allowed charges are less than the deductible amount, and therefore, no program payments are due.

Dollar amounts for physician/supplier services in any time period may be portrayed either on a cash flow basis (i.e., the period in which a payment was made) or on an accrued basis (i.e., the period in which an expense was incurred). Dollar amounts in this section represent accrued amounts.

General Trends

- Total potential liabilities for physician/supplier of services increased six-fold between 1975 and 1987 (Table 1, Figure 1). Program payments as a percent of total potential liabilities increased steadily from 61 percent in 1975 to over 70 percent in 1987 except for a brief interruption in 1982 when the annual SMI deductible amount was raised from $60 to $75. Balance billing as a percent of total potential liabilities steadily increased from 1975 to 1984 but, subsequently, has generally declined primarily due to the Medicare Physician Participation Program. Deductibles as a percent of total potential liabilities have decreased steadily, from nearly 15 percent of total liabilities in 1975 to less than 5 percent in 1987, except for 1982 when the annual deductible amount increased.

- Table 1 excludes amounts paid on Medicare Secondary Payer claims by private insurers. The amount of such payments on claims submitted to Part B Carriers was $468 million in fiscal year 1988.

- Annual rates of increase in total potential liabilities have exceeded 10 percent in all years except 1985 and 1986 (Table 2, Figure 2). However, rates of increase were much higher prior to 1982. The average annual rate of growth in program payments between 1975 and 1987

(17 percent) was about 1 percentage point larger than the average annual rate of growth in allowed charges (16 percent), due primarily to the diminishing effect of the relatively fixed annual deductible amounts in a period of increasing inflation in physician charges. The percentage of enrollees exceeding the SMI deductible and receiving payments for physician/supplier services increased from 48 percent in 1975 to nearly 70 percent in 1986 (Table 3, Figure 3).

- Preliminary data indicate that incurred approved charges billed to Part B Carriers were about $33 billion in Calendar Year 1988, up about 10 percent from 1987. A rate of increase was well below that for 1987 over 1986, 15.8 percent. Estimated total incurred potential liabilities for physician and other non-institutional supplier services, including balance billing amounts, were about $35.5 billion in 1988, about 8.9 percent above 1987. Balance billing amounts continued to decline in 1988 both in absolute dollar amounts (about $2.3 billion in 1988 compared to $2.5 billion in 1987) and as a percent of total potential liabilities for physician and other non-institutional supplier services (about 6.5 percent in 1988 compared to 7.7 percent in 1987.

- The relatively slow growth in allowed charges in 1985 and 1986 appears to be related in part to limitations on prevailing charge increases imposed by DEFRA, 1984 and by the Emergency Extension Act, 1985 (Table 2). Other limitations on prevailing charge increases imposed by OBRA, 1987, appear to have limited the rate of growth in allowed charges in 1988.

- Total Medicare per capita potential liabilities in current dollars for physician/supplier services increased from $227 in 1975 to nearly $1,000 in 1987 (Table 4, Figure 4). Over the period 1975 to 1987, program expenditures increased at a faster average annual rate, 14.4 percent, than beneficiary potential liabilities, 10.5 percent. Although the balance billing portion of beneficiary liabilities increased at a faster average annual rate over the period 1975 to 1987, 11.3 percent, than copayments (i.e., deductibles and coinsurance), 10.5 percent, balance billing dollar amounts per capita dropped sharply in 1987.

- Over the period 1975 to 1987, total Medicare potential liabilities in constant dollars increased at an average annual rate of 6.8 percent (Table 5). Program expenditures in constant dollars increased at an average annual rate of 8.0 percent compared to 4.4 percent for beneficiary potential liabilities.

Shares of the General Economy and National Health Spending

- Liabilities for physician/supplier services both as a proportion of total health spending by the general population and as a proportion of the gross national product (GNP) increased steadily over the period 1975 to 1987 (Table 6). While national health spending as a percent of the GNP grew from 8.3 to 11.0 from 1975 to 1987, Medicare physician/supplier liabilities as a percent of national health spending grew from 4.3 to 6.5 percent. As a consequence, liabilities for Medicare physician/supplier services as a percent of the GNP doubled over the period. These liabilities as a percent of the general population's expenditures for physician services and durable medical equipment (DME) grew from 20.5 percent in 1975 to 29.1 percent in 1987. Physician/supplier program payments as a percent of the GNP grew even faster than total liabilities for these services because program payments comprise an increasing proportion of total liabilities.

- Part of the growth in physician/supplier services as a percent of the GNP and National Health Expenditures (NHE) is due to the faster annual rate of growth of the Medicare population, about 2 percent, than in the general population, about 1 percent. Increases in Medicare enrollments above the general population growth accounted for only 15 percent of the increase in liabilities as a proportion of the GNP. Medicare prices and services per capita, which together rose faster than general prices and general outputs per capita, accounted for the remaining 85 percent of the increase in liabilities as a percent of the GNP.

- Faster growth in Medicare populations accounted for about a third of the increases in physician/supplier liabilities as a percent of national health spending. Faster growth in Medicare prices and per capita utilization accounted for the remaining two thirds.

Allowed Charges by Place and by Type of Service

- Total allowed charges for physician/supplier services increased from $5.2 billion in 1975 to $30.1 billion in 1987, nearly a six-fold increase (Tables 7 and 8). Other relative shares of major types of service have changed significantly since the onset of PPS. From 1975 through 1980, medical services dominated, claiming about

10 percentage points more of allowed charges than the second largest category, surgical services (Tables 7 and 8). After 1980, the difference in shares between medical and surgical services began to diminish, and by 1986 surgical charges exceeded medical charges. Another significant growth in shares occurred for "other" types of service, a category which includes durable medical equipment and other medical suppliers, ambulance services, and for recent years, ambulatory surgical care facility charges. In 1975, "Other" types of service comprised less than 6 percent of all allowed charges, a share which grew to 11.5 percent in 1987.

- From 1975 to 1983, allowed charges for surgical services in inpatient hospital settings were the largest single source of growth in total allowed charges and increases in medical services in inpatient hospital settings were the next largest source of growth (Table 9, Figure 5). Together, these two categories contributed 43 percent of total growth in charges from 1975 to 1980 and 37 percent of the total growth in charges from 1980 to 1983. However, from 1983 to 1986 these inpatient sectors contributed nothing to the increase in total allowed charges. From 1983 to 1986, office medical charges and outpatient facility surgical charges were the largest source of growth. (Charges for services rendered in ambulatory surgical centers have been combined within each type of service with those services rendered in outpatient facilities in this compendium.) From 1986 to 1987, charges for medical and surgical services in inpatient hospital settings began to resume their contribution to increases in total charges. Although physician charges for inpatient services as a share of total allowed charges continued to decrease from 1986 to 1987 (Table 7) due to the rapid growth in other sectors, the decline in inpatient hospitalizations observed in recent years ended in 1987 and physician services in inpatient settings again began to contribute more heavily to total increases in charges. In 1987, total Medicare admissions, that is fee-for-service plus HMO admissions, and total days of care, which had been declining since 1983 through 1986, increased. Patient days for Medicare enrollees as reported by the American Hospital Association (AHA) declined from 114.3 million in 1983 to 94.9 million in 1987. Recent reports by the AHA indicate an accelerating rate of increase in Medicare days of care in 1988 (see Section I, Table 7). It is estimated that if inpatient hospital trends observed prior to 1987 had continued in 1987, total

physician charges would have been about $1 billion less than those actually observed.

- Trends in relative shares for physician charges in inpatient settings are seen more clearly if charge shares in only three places of service, office, inpatient hospital and outpatient facility, are measured (Table 10, Figure 6). In 1980, charges in inpatient hospital settings accounted for nearly two thirds of all charges for these three places of service. By 1987, inpatient shares had declined to less than half the total, while office shares increased modestly and outpatient facility shares, particularly for surgical services, increased rapidly.

- No general price index is available for Medicare physician average allowed charges. However, price trends for office and inpatient hospital visits may be inferred from Laspeyres indices which are based on 1985 relative weights for each category of visit and 1985, 1986, and 1987 charges for each category of visit.

  - Prices for office visits increased about 3.4 percent from 1985 to 1986 and about 8.6 percent from 1986 to 1987.

  - Prices for inpatient hospital visits increased about 3.1 percent from 1985 to 1986 and about 10.6 percent from 1986 to 1987.

  - Weighted price increase for combined office and inpatient visits increased about 3.3 percent from 1985 to 1986 and about 9.5 percent from 1986 to 1987.

  The difference between price increases and average charge per visit increase represents a measure of upcoding of services in the family groups. Thus,

  - "upcoding" accounted for about 0.8 percentage points of the 4.2 percent increase in average office visit charges from 1985 to 1986 and about 0.7 percentage points of the 9.4 percent increase in average office visit charges from 1986 to 1987.

  - "upcoding" accounted for about 1.9 percentage points of the 5.0 percent increase in average inpatient hospital visit charges from 1987 to 1986 and about 0.6 percentage points of the 11.3 percent increase in average inpatient hospital visit charges from 1986 to 1987.

As explained in the Sources and Limitations Section for Tables 11 and 12, data for six carriers have been omitted from these computations.

Some Regional Differences

- Actual allowed average charges per physician visit by HCFA Region vary from $26.10 in the Denver Region to $44.29 in the San Francisco Region for physician inpatient hospital visits and from $18.74 in the Kansas City Region to $32.32 in the San Francisco Region for physician office visits (Table 13).

- If adjustments in actual allowed average charges for relative differences in prices only are made (i.e., using the national structure of visits and the regional actual charges by type of visit), an approximate price index can be constructed which portrays relative price differences between regions. The price index for inpatient hospital visits varies from .830 in the Denver Region to 1.297 in the San Francisco Region and, for office visits, from .803 in the Kansas City Region to 1.275 in the San Francisco Region (Table 13, Figure 8).

- "Price" indices (comparing regional to national averages) for office visits substantially exceed indices for hospital visits in the Boston and the New York Regions. The index for hospital visits substantially exceeds that for office visits in the Dallas and the Philadelphia Regions (Table 13, Figure 8).

- The distribution of total allowed charges by HCFA region and by place of service follows closely regional variations in inpatient hospital admission rates and days of care (Table 14). Lowest percentages of charges incurred in inpatient settings occur in the coastal and mountain regions (generally 40 percent or less) and the highest percentages occur in the heartland regions.

Sources and Limitations

The reader is strongly urged to review the Sources and Limitations portion of this Compendium for Section III.

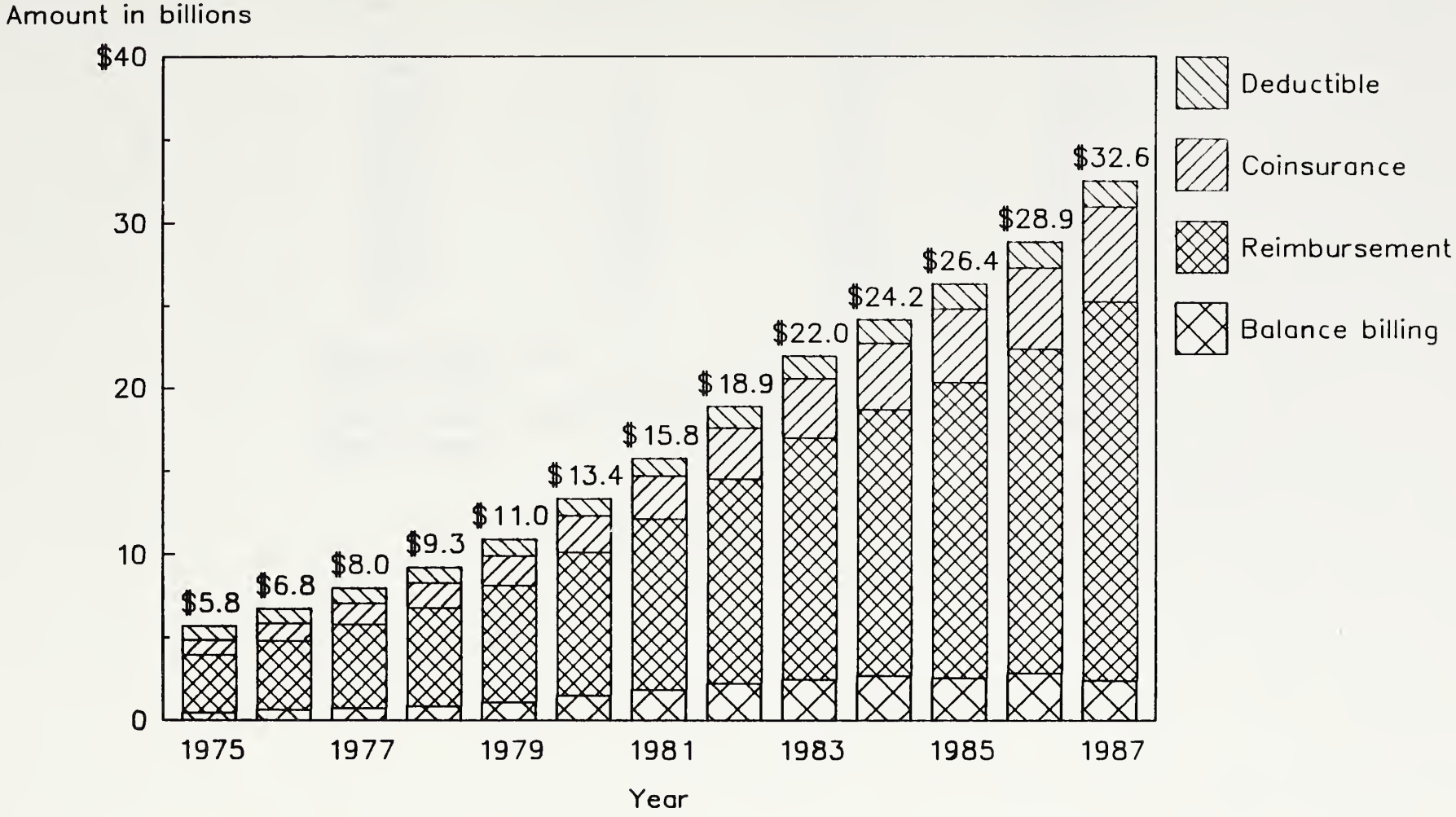
Table 1
Estimated Medicare dollar amounts of total potential liability for physicians and other non-institutional suppliers of Medicare covered goods and services and components of total liability: Calendar years 1975 to 1987

Calendar year	Total potential liability 1/	Balance billing	Allowed charges			
			Total	Program payments	Coinsurance amount	Deductible amount
	Dollars in millions					
1987	$32,550	$2,500	$30,050	$22,800	$5,700	$1,550
1986	28,892	2,947	25,945	19,500	4,875	1,570
1985	26,362	2,657	23,705	17,753	4,438	1,514
1984	24,190	2,788	21,402	15,967	3,992	1,443
1983	21,990	2,559	19,431	14,478	3,587	1,366
1982	18,922	2,323	16,599	12,250	3,030	1,319
1981	15,781	1,940	13,840	10,249	2,536	1,056
1980	13,371	1,586	11,785	8,628	2,132	1,026
1979	10,962	1,187	9,775	7,047	1,739	989
1978	9,302	941	8,361	5,942	1,464	955
1977	8,046	825	7,221	5,059	1,245	918
1976	6,805	730	6,077	4,172	1,023	883
1975	5,762	544	5,218	3,512	862	845
	Percent distribution					
1987	100.0%	7.7%	92.3%	70.0%	17.5%	4.8%
1986	100.0	10.2	89.8	67.5	16.9	5.4
1985	100.0	10.1	89.9	67.3	16.8	5.7
1984	100.0	11.5	88.4	66.0	16.5	6.0
1983	100.0	11.6	88.4	65.8	16.3	6.2
1982	100.0	12.3	87.7	64.7	16.0	7.0
1981	100.0	12.3	87.7	64.9	16.1	6.7
1980	100.0	11.9	88.1	64.5	15.9	7.7
1979	100.0	10.8	89.2	64.3	15.9	9.0
1978	100.0	10.1	89.9	63.9	15.7	10.3
1977	100.0	10.3	89.7	62.9	15.5	11.4
1976	100.0	10.7	89.3	61.3	15.0	13.0
1975	100.0	9.4	90.6	61.0	15.0	14.7

1/ Total potential liabilities are the sum of balance billings, program payments, coinsurance amounts and deductible amounts. The amounts of potential liabilities for balance billing, coinsurance and deductibles actually collected is unknown.

SOURCE: HCFA, BDMS, Medicare Statistical System, and BPO Workload Report System.

Figure 1
Dollar amounts of total potential liability for Medicare physicians and other non-institutional suppliers



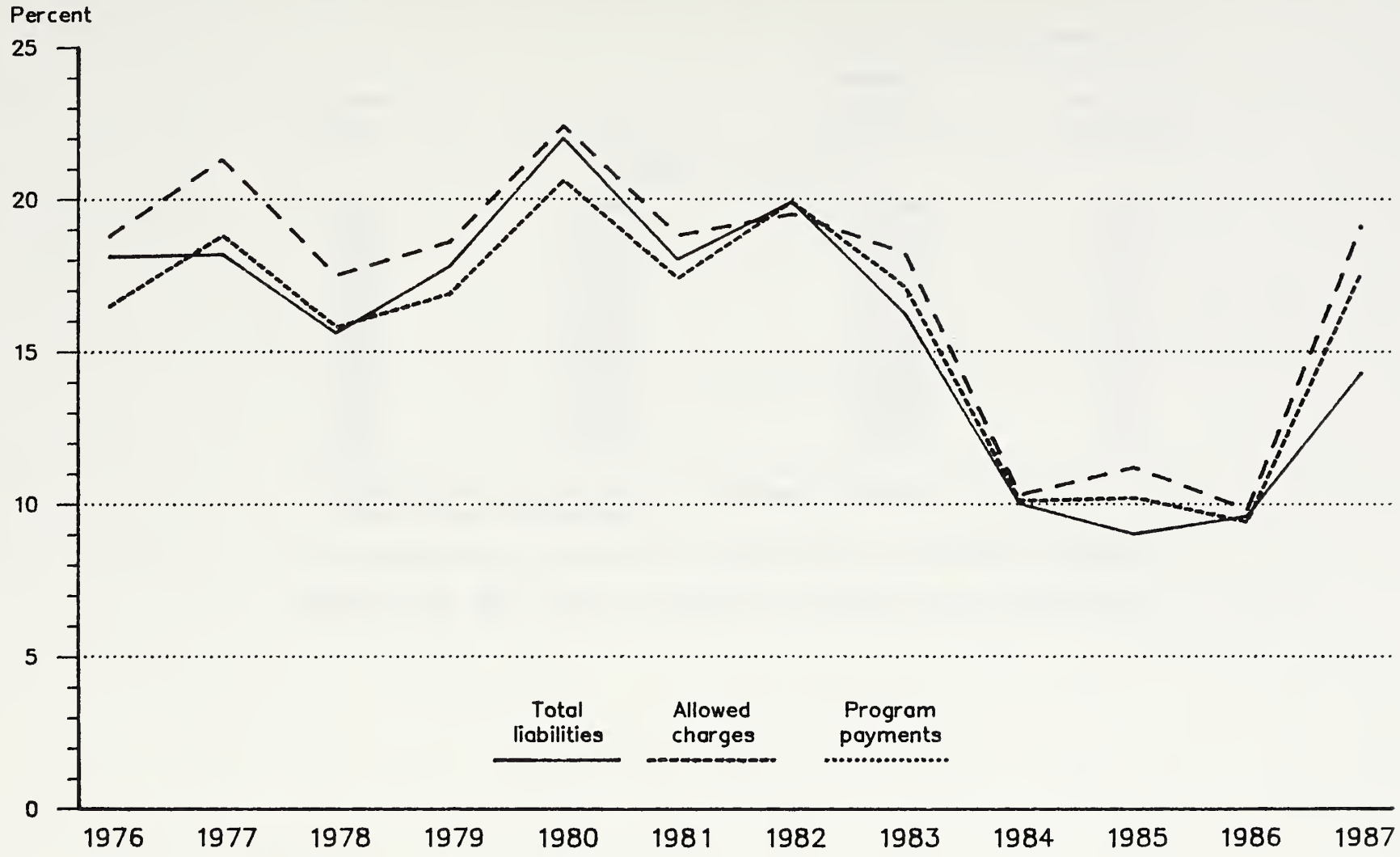
Prepared by the Division of Information Analysis

Table 2
Medicare annual rate of change in total liabilities, allowed charges and program payments:
Calendar years 1975 to 1987

Calendar year	Total liabilities	Allowed charges	Program payments
1987	12.7%	15.8%	16.9%
1986	9.6	9.4	9.8
1985	9.0	10.2	11.2
1984	10.0	10.1	10.3
1983	16.2	17.1	18.2
1982	19.9	19.9	19.5
1981	18.0	17.4	18.8
1980	22.0	20.6	22.4
1979	17.8	16.9	18.6
1978	15.6	15.8	17.5
1977	18.2	18.8	21.3
1976	18.1	16.5	18.8
Average annual rate, 1975 to 1987	15.5	15.7	16.9

SOURCE: HCFA, BDMS, Medicare Statistical System, and BPO Workload Report System.

Figure 2
Annual rate of change in total liabilities, allowed charges and program payments, Calendar years 1975 to 1987



Prepared by the Division of Information Analysis

Table 3
Medicare persons enrolled for Supplementary Medical Insurance (SMI) and persons receiving benefits for physician and other non-institutional supplier goods and services: Calendar years 1975 to 1986

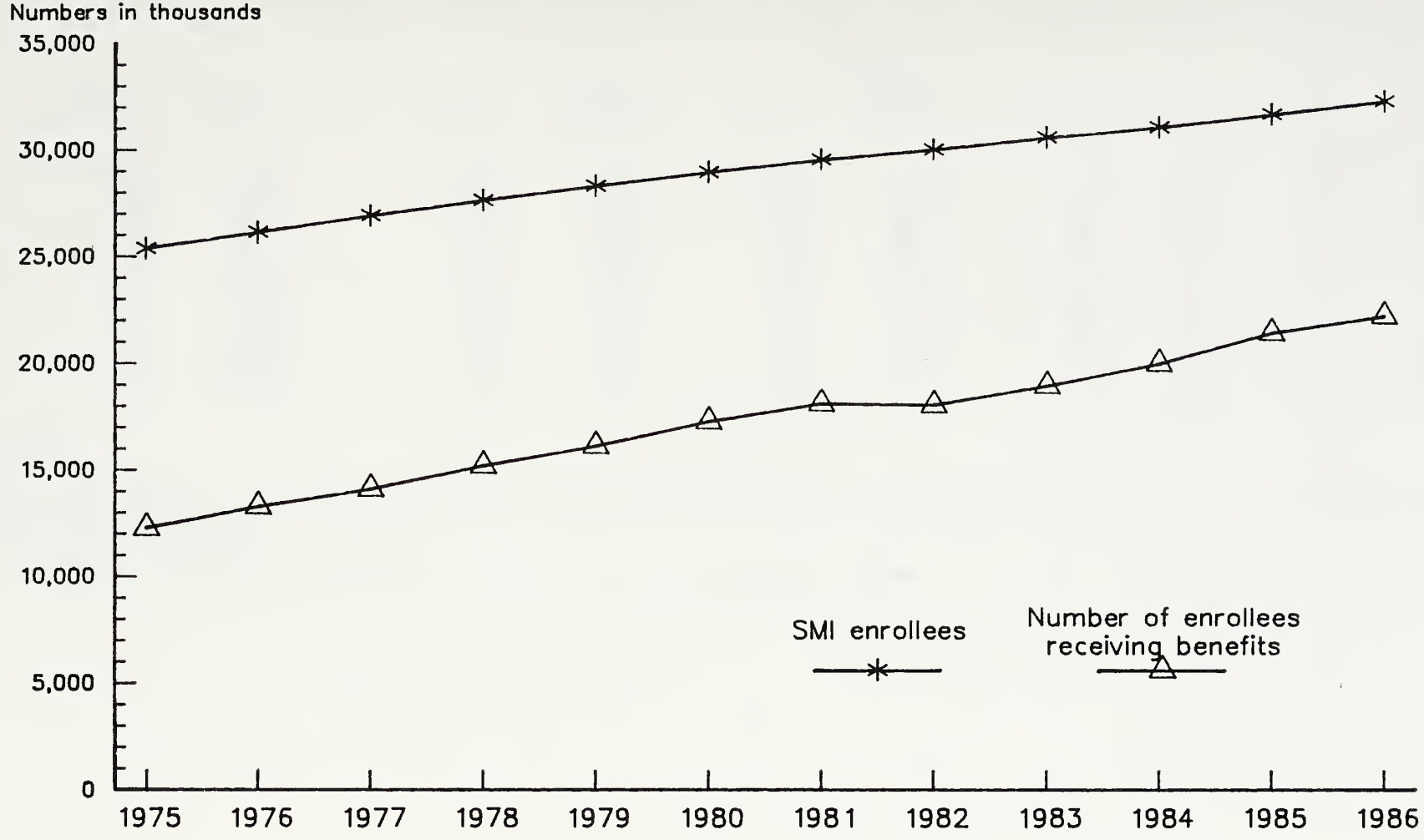
Calendar year	Enrollment 1/	Persons receiving benefits 2/	
		Number receiving benefits	Percent of enrollment
	Numbers in thousands		
1986	32,280	22,205	68.8%
1985	31,655	21,410	67.6
1984	31,030	19,960	64.3
1983	30,557	18,923	61.9
1982	29,990	18,017	60.1
1981	29,522	18,097	61.3
1980	28,935	17,258	59.6
1979	28,292	16,105	56.9
1978	27,617	15,182	55.0
1977	26,898	14,096	52.4
1976	26,123	13,279	50.8
1975	25,369	12,261	48.2

1/ Persons with eligibility for Supplementary Medical Insurance at any time in the calendar year.

2/ Persons receiving services for which there were Medicare payments.

SOURCE: HCFA, BDMS, Medicare Statistical System, Person Summary File.

Figure 3
Persons enrolled for SMI and persons receiving benefits for physician and other non-institutional supplier goods and services



Prepared by the Division of Information Analysis

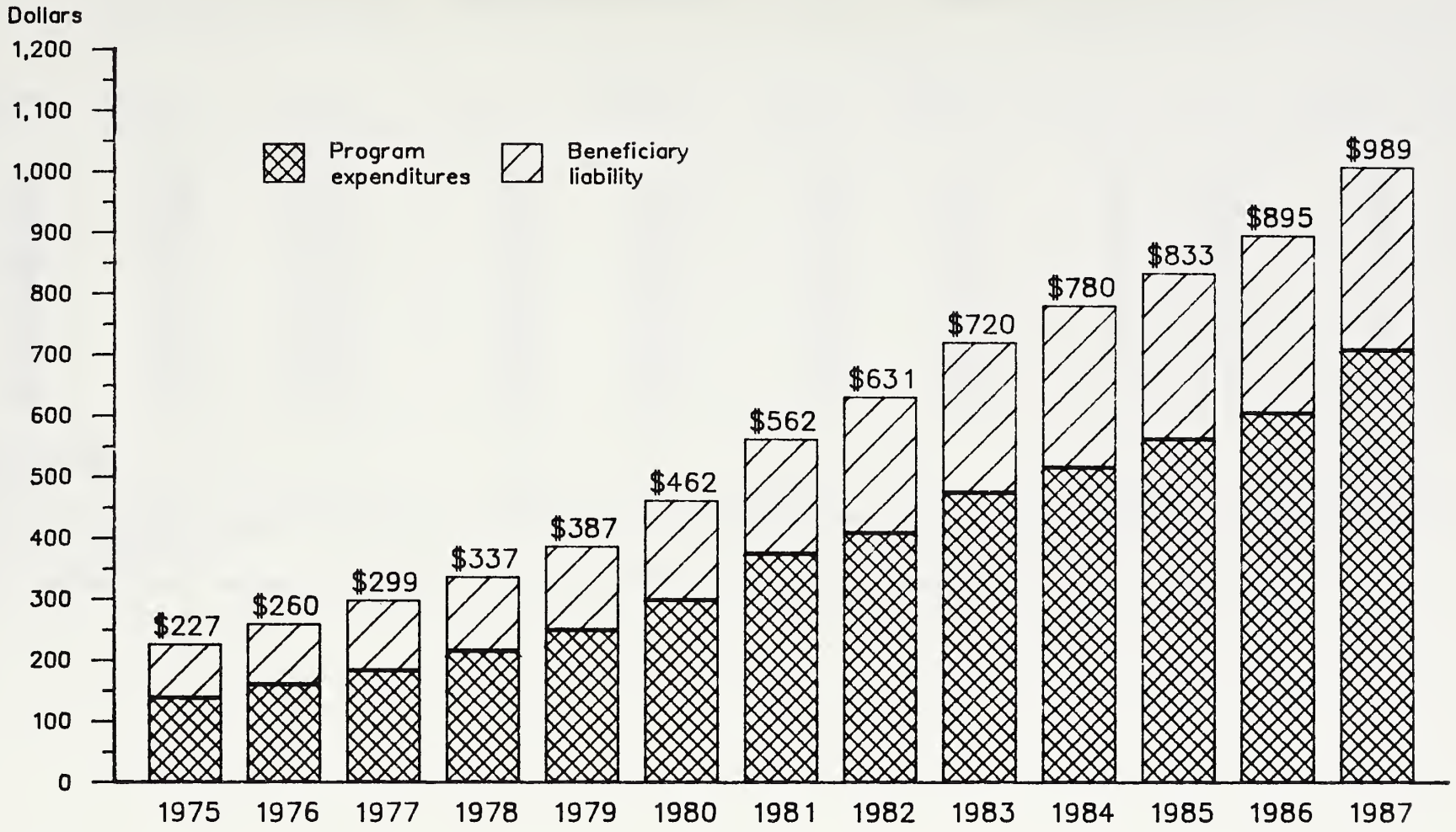
Table 4
Per Enrollee Amounts: Medicare total potential liability, program expenditures, and beneficiary out-of-pocket liability, in current dollars: Calendar years 1975 to 1987

Calendar year	Total potential liability 1/		Program expenditures		Beneficiary potential liability 1/					
					Total		Balance billing		Copayments	
	Amount	Percent	Amount	Percent of total liability	Amount	Percent of total liability	Amount	Percent	Amount	Percent
1987	$989	100.0%	$693	70.1%	$296	29.9%	$76	7.7%	$221	22.3%
1986	895	100.0	604	67.5	291	32.5	91	10.2	200	22.3
1985	833	100.0	561	67.3	272	32.8	84	10.1	188	22.6
1984	780	100.0	515	66.0	265	34.0	90	11.5	175	22.5
1983	720	100.0	474	65.8	246	34.2	84	11.6	162	22.5
1982	631	100.0	408	64.7	223	35.3	77	12.3	145	23.0
1981	562	100.0	374	65.0	188	35.0	66	11.7	122	21.6
1980	462	100.0	298	64.5	164	35.5	55	11.9	109	23.6
1979	387	100.0	249	64.3	138	35.7	42	10.8	96	24.9
1978	337	100.0	215	63.9	122	36.1	34	10.1	88	26.0
1977	299	100.0	183	62.9	116	37.1	31	10.3	80	26.9
1976	260	100.0	160	61.3	100	38.7	28	10.7	73	28.1
1975	227	100.0	138	61.0	89	39.0	21	9.4	67	29.6
Average annual percentage chg. 1975-1987	13.0		14.4		10.5		11.3		10.5	

1/ "Potential" liability represents dollar amounts incurred for services of providers. Amounts of beneficiary potential liability actually collected are unknown.

SOURCE: HCFA, BDMS, Medicare Statistical System, and BPO Workload Report System.

Figure 4
Total liability, program expenditures, and beneficiary liability per Medicare enrollee, Calendar years 1975 to 1987



SOURCE: HCFA, BDMS, Medicare Statistical System

Table 5

Per Enrollee Amounts: Medicare total potential liability, program expenditures, and beneficiary out-of-pocket liability, in constant dollars: Calendar years 1975 to 1987 1/

Calendar year	Total potential liability		Program expenditures		Beneficiary potential liability					
					Total		Balance billing		Copayments	
	Amount	Percent	Amount	Percent of total liability	Amount	Percent of total liability	Amount	Percent	Amount	Percent
1987	$498	100.0%	$349	70.1%	$149	29.9%	$38	7.7%	$111	22.3%
1986	466	100.0	314	67.5	151	32.5	48	10.2	104	22.3
1985	445	100.0	300	67.3	145	32.7	45	10.1	100	22.6
1984	429	100.0	283	66.0	146	34.0	49	11.5	96	22.5
1983	411	100.0	271	65.8	140	34.2	48	11.6	93	22.5
1982	374	100.0	242	64.7	132	35.3	46	12.3	86	23.0
1981	355	100.0	236	66.5	119	33.5	41	11.7	77	21.6
1980	320	100.0	206	64.5	113	35.5	38	11.9	76	23.6
1979	292	100.0	188	64.3	104	35.7	32	10.8	73	24.9
1978	277	100.0	177	63.8	100	36.2	28	10.1	72	26.0
1977	264	100.0	161	61.2	102	38.8	27	10.3	71	26.9
1976	245	100.0	151	61.5	94	38.5	26	10.7	69	28.1
1975	227	100.0	138	60.8	89	39.2	21	9.4	67	29.6
Average annual percentage chg. 1975-1987	6.8		8.0		4.4		5.1		4.3	

1/ All current dollar amounts from Table 4 have been deflated by the GNP Implicit Price Deflator in this table (1975=100.0).

SOURCE: HCFA, BDMS, Medicare Statistical System, and BPO Workload Report System.

Table 6
Total Medicare liability, allowed charges, and program payments as a percent of national health expenditures and of gross national product: Calendar years 1975 to 1987 1/

Calendar year	National health expenditures (NHE)	Gross national product (GNP)	Total liability as a percent of: NHE	Total liability as a percent of: GNP	Total liability as a percent of: Total physician and DME expenditures 2/	Allowed charges as a percent of: NHE	Allowed charges as a percent of: GNP	Program payments as a percent of: NHE	Program payments as a percent of: GNP
	Dollars in billions								
1987	$500.3	$4,527	6.50%	0.72%	29.1%	6.01%	0.66%	4.55%	0.50%
1986	455.7	4,240	6.34	0.68	28.8	5.69	0.61	4.28	0.46
1985	419.0	4,015	6.29	0.66	29.6	5.66	0.59	4.24	0.44
1984	388.5	3,772	6.23	0.64	29.7	5.51	0.57	4.11	0.42
1983	357.2	3,406	6.16	0.65	29.5	5.44	0.57	4.05	0.43
1982	323.6	3,166	5.85	0.60	28.0	5.13	0.52	3.79	0.36
1981	287.0	3,053	5.50	0.52	26.2	4.82	0.45	3.57	0.34
1980	248.1	2,732	5.39	0.49	25.8	4.75	0.43	3.48	0.32
1979	214.7	2,508	5.11	0.44	24.4	4.55	0.39	3.28	0.28
1978	189.7	2,250	4.90	0.41	23.3	4.41	0.37	3.13	0.26
1977	169.9	1,991	4.74	0.40	22.6	4.25	0.36	2.98	0.25
1976	150.8	1,783	4.51	0.38	22.0	4.03	0.34	2.77	0.23
1975	132.7	1,590	4.34	0.36	20.5	3.93	0.33	2.65	0.22

1/ Dollar amounts for total liability, allowed charges and program payments are shown in Section III, Table 1.

2/ Medicare total liability as a percent of expenditures for physician/supplier services, independent laboratories, and durable medical equipment (DME) by the entire population.

SOURCE: HCFA, OACT, National Health Expenditures Series, BDMS, Medicare Statistical System, and BPO, Workoad Report System.

Table 7

Estimated Medicare amount of allowed charges and percent distribution of allowed charges for physicians/suppliers by type and place of service: Calendar years 1980 to 1987

Type and place of service	1987		1986		1985		1984		1983		1982		1981		1980	
	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent
	Dollars in millions															
Total	$30,050.0	100.0%	$25,945.0	100.0%	$23,705.0	100.0%	$21,402.0	100.0%	$19,431.0	100.0%	$16,599.0	100.0%	$13,840.0	100.0%	$11,815.5	100.0%
Medical care	9,075.1	30.2	7,872.2	30.3	7,460.3	31.5	6,999.0	32.7	6,675.8	34.4	5,969.0	36.0	5,211.2	37.7	4,668.5	39.5
Office	4,376.4	14.6	3,727.5	14.4	3,456.3	14.6	3,053.0	14.3	2,738.7	14.1	2,403.7	14.5	2,210.4	16.0	2,032.7	17.2
Inpatient	3,575.9	11.9	3,247.1	12.5	3,206.8	13.5	3,269.7	15.3	3,368.4	17.3	3,044.3	18.3	2,560.6	18.5	2,239.4	19.0
Outpatient hospital	556.9	1.9	493.5	1.9	359.3	1.5	297.4	1.4	238.4	1.2	222.9	1.3	185.8	1.3	158.9	1.3
Other	565.9	1.9	404.1	1.6	437.9	1.8	379.0	1.8	330.3	1.7	298.1	1.8	254.4	1.8	237.5	2.0
Surgical	9,165.3	30.5	7,986.1	30.8	7,156.2	30.2	6,472.5	30.2	5,709.5	29.4	4,781.3	28.8	3,919.6	28.3	3,338.0	28.3
Office	1,441.6	4.8	1,241.0	4.8	1,088.2	4.6	878.2	4.1	738.3	3.8	601.2	3.6	481.1	3.5	390.6	3.3
Inpatient	5,046.9	16.8	4,551.5	17.5	4,463.4	18.8	4,801.1	22.4	4,546.6	23.4	3,919.2	23.6	3,261.4	23.6	2,816.6	23.8
Outpatient hospital	2,550.7	8.5	2,096.4	8.1	1,526.7	6.4	735.7	3.4	382.1	2.0	228.2	1.4	150.7	1.1	111.7	0.9
Other	126.1	0.4	97.1	0.4	77.9	0.3	57.5	0.3	42.5	0.2	32.7	0.2	26.4	0.2	19.1	0.2
Consultation	1,141.9	3.8	818.1	3.2	699.4	3.0	659.4	3.1	595.6	3.1	502.0	3.0	400.2	2.9	323.5	2.7
Office	292.0	1.0	175.5	0.7	148.1	0.6	121.9	0.6	104.1	0.5	85.1	0.5	67.2	0.5	56.3	0.5
Inpatient	778.2	2.6	603.1	2.3	519.4	2.2	509.4	2.4	468.1	2.4	398.0	2.4	318.1	2.3	255.8	2.2
Outpatient hospital	46.3	0.2	22.0	0.1	18.2	0.1	14.9	0.1	12.0	0.1	10.0	0.1	8.2	0.1	5.8	0.1
Other	25.4	0.1	17.5	0.1	13.7	0.1	13.2	0.1	11.4	0.1	9.0	0.1	6.6	0.1	5.6	0.1
Diagnostic x-ray	2,644.4	8.8	2,213.5	8.5	1,918.6	8.1	1,700.9	7.9	1,515.4	7.8	1,238.1	7.5	1,001.4	7.2	806.5	6.8
Office	1,056.5	3.5	851.2	3.3	775.0	3.3	635.0	3.0	554.9	2.9	471.3	2.8	388.8	2.8	321.9	2.7
Inpatient	920.4	3.1	826.0	3.2	742.3	3.1	742.5	3.5	704.9	3.6	573.2	3.5	452.1	3.3	357.9	3.0
Outpatient hospital	588.4	2.0	469.8	1.8	335.3	1.4	267.4	1.2	210.2	1.1	156.9	0.9	129.8	0.9	94.1	0.8
Other	79.1	0.3	66.4	0.3	66.0	0.3	56.0	0.3	45.4	0.2	36.6	0.2	31.6	0.2	32.6	0.3

Table 7 (continued)

Type and place of service	1987		1986		1985		1984		1983		1982		1981		1980	
	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent
	Dollars in millions															
Clinical lab	2,794.7	9.3	2,439.1	9.4	2,184.4	9.2	1,952.5	9.1	1,798.0	9.3	1,519.1	9.2	1,252.4	9.1	1,014.2	8.6
Office	1,217.5	4.0	1,073.8	4.1	983.4	4.1	931.0	4.4	832.0	4.3	704.9	4.2	577.3	4.2	470.5	4.0
Inpatient	468.0	1.6	451.5	1.7	435.2	1.8	457.4	2.1	524.0	2.7	456.0	2.7	368.3	2.7	297.4	2.5
Outpatient hospital	188.9	0.6	164.3	0.6	122.1	0.5	94.0	0.4	68.7	0.4	53.7	0.3	47.1	0.3	37.0	0.3
Other	920.3	3.1	749.4	2.9	643.7	2.7	470.1	2.2	373.2	1.9	304.5	1.8	259.7	1.9	209.4	1.8
Radiation therapy	376.0	1.3	314.5	1.2	273.7	1.2	238.1	1.1	214.7	1.1	180.4	1.1	161.7	1.2	125.2	1.1
Office	163.2	0.5	134.1	0.5	110.5	0.5	87.8	0.4	73.8	0.4	60.0	0.4	51.4	0.4	38.3	0.3
Inpatient	42.4	0.1	41.1	0.2	37.1	0.2	41.9	0.2	49.4	0.3	53.8	0.3	56.8	0.4	47.0	0.4
Outpatient hospital	159.6	0.5	131.3	0.5	118.4	0.5	101.6	0.5	86.0	0.4	62.9	0.4	50.9	0.4	37.7	0.3
Other	10.8	0.0	8.0	0.0	7.7	0.0	6.8	0.0	5.5	0.0	3.6	0.0	2.6	0.0	2.3	0.0
Anesthesia	1,093.8	3.6	981.6	3.8	945.0	4.0	871.7	3.7	805.8	4.1	695.2	4.2	579.3	4.2	473.0	4.0
Office	5.7	0.0	6.9	0.0	9.1	0.0	4.3	0.0	3.3	0.0	2.5	0.0	1.3	0.0	1.1	0.0
Inpatient	860.2	2.9	777.2	3.0	808.6	3.4	819.3	3.5	783.7	4.0	681.5	4.1	579.1	4.1	467.9	4.0
Outpatient hospital	221.3	0.7	191.4	0.7	119.7	0.5	44.1	0.2	18.2	0.1	11.0	0.1	7.0	0.1	2.9	0.0
Other	6.6	0.0	6.1	0.0	7.7	0.0	3.9	0.0	0.6	0.0	0.2	0.0	0.0	0.0	1.1	0.0
Assistant at surgery	313.1	1.0	322.9	1.2	356.8	1.5	327.2	1.4	291.3	1.5	254.3	1.5	208.7	1.5	193.9	1.6
Office	3.9	0.0	4.9	0.0	7.6	0.0	4.1	0.0	3.8	0.0	3.1	0.0	2.6	0.0	2.3	0.0
Inpatient	283.0	0.9	285.6	1.1	284.2	1.2	294.1	1.2	278.2	1.4	247.7	1.5	204.6	1.5	190.5	1.6
Outpatient hospital	22.3	0.0	30.2	0.1	62.0	0.3	27.8	0.1	8.9	0.0	3.4	0.0	1.4	0.0	1.1	0.0
Other	4.0	0.0	2.2	0.0	3.1	0.0	1.3	0.0	0.3	0.0	0.1	0.0	0.0	0.0	0.0	0.0
Other	3,445.7	11.5	2,997.1	11.6	2,710.7	11.4	2,180.8	9.2	1,825.0	9.4	1,459.7	8.8	1,106.0	8.0	872.4	7.4
Office	332.7	1.1	294.7	1.1	162.8	0.7	100.9	0.4	86.3	0.4	80.8	0.5	64.6	0.5	54.0	0.5
Inpatient	36.7	0.1	34.9	0.1	64.7	0.3	18.9	0.1	82.2	0.4	84.3	0.5	64.0	0.5	49.8	0.4
Outpatient hospital	321.0	1.1	159.4	0.6	50.8	0.2	23.3	0.1	14.6	0.1	12.3	0.1	8.5	0.1	6.7	0.1
Other	2,755.3	9.2	2,508.2	9.7	2,432.4	10.3	2,037.7	8.6	1,642.0	8.5	1,282.2	7.7	968.9	7.0	761.9	6.5

NOTE: Data for services rendered in ambulatory surgical centers are included in outpatient hospital.

SOURCE: HCFA, BDMS, BMAD System, 1985 - 1987; Physician Summary Record System, 1980 - 1984.

Table 8
Estimated Medicare amount of allowed charges and percent distribution of allowed charges by type of physician and non physician suppliers, by type and place of service: Calendar years 1975 to 1979

	1979		1978		1977		1976		1975	
	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent
	Amounts in millions									
Total	$9,775.0	100.0%	$8,361.0	100.0%	$7,202.0	100.0%	$6,077.0	100.0%	$5,218.0	100.0%
Medical	3,831.8	39.2	3,337.1	39.9	2,954.4	41.1	2,568.2	42.3	2,205.7	42.3
Office	1,765.5	18.1	1,540.9	18.4	1,373.5	19.1	1,197.9	19.7	1,030.9	19.8
Inpatient hospital	1,762.4	18.0	1,545.0	18.5	1,360.0	18.9	1,171.6	19.3	1,005.5	19.3
Outpatient hospital	115.4	1.2	91.0	1.1	76.3	1.1	62.5	1.0	45.6	0.9
Other	188.5	1.9	160.1	1.9	149.7	2.1	136.3	2.2	133.7	2.4
Surgical	2,835.6	29.0	2,399.3	28.7	2,022.4	28.1	1,668.4	27.5	1,465.5	28.1
Inpatient hospital	2,147.5	22.0	1,882.0	22.5	1,645.0	22.8	1,408.1	23.2	1,238.9	23.7
Other	688.1	7.0	518.3	6.2	377.4	5.2	260.3	4.3	226.6	4.3
Consultation	271.7	2.8	225.6	2.7	182.2	2.5	143.3	2.4	123.9	2.4
Diagnostic x-ray	668.3	6.8	562.6	6.7	491.9	6.8	420.7	6.9	350.8	6.7
Clinical laboratory	849.0	8.7	722.1	8.6	631.6	8.8	540.0	8.9	462.1	8.8
Radiation therapy	118.8	1.2	110.1	1.3	80.7	1.1	56.0	0.9	44.2	0.8
Anesthesia	405.1	4.1	353.9	4.2	296.7	4.1	243.1	4.0	203.6	3.9
Assistant at surgery	135.5	1.4	109.3	1.3	94.4	1.3	79.6	1.3	69.9	1.3
Other	659.2	6.7	540.7	6.5	442.9	6.2	358.0	5.9	292.3	5.6

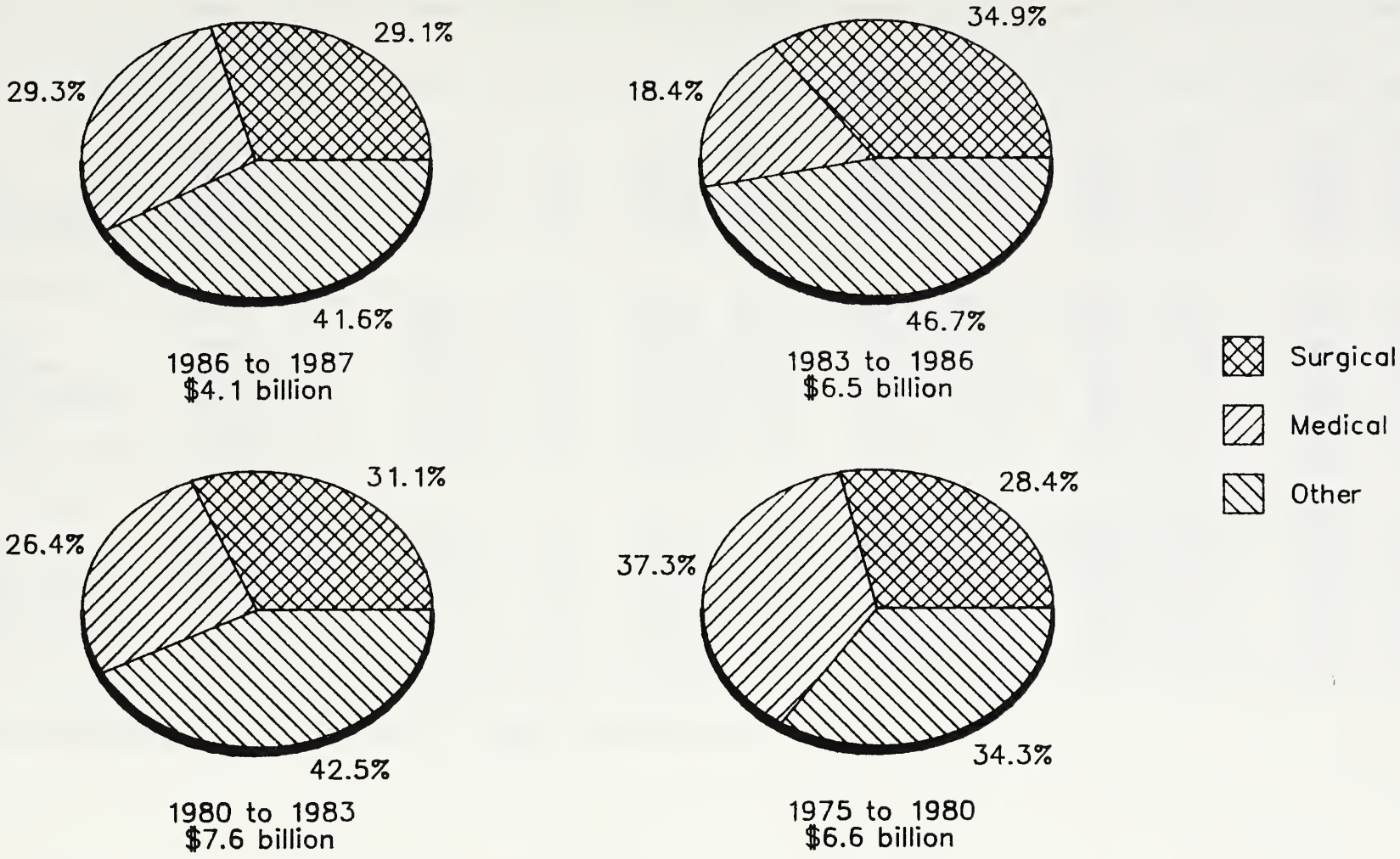
SOURCE: HCFA, BDMS, Physician Summary Record System.

Table 9
Sources of increase in allowed Medicare charges by type and selected places of service: Calendar years 1975 to 1987

Type and place	1986 to 1987	1983 to 1986	1980 to 1983	1975 to 1980
	Dollars in millions			
Total	$4,105	$6,514	$7,616	$6,597
	Percent distribution			
Total	100.0%	100.0%	100.0%	100.0%
Medical	29.3	18.4	26.4	37.3
Office	15.6	15.1	9.3	15.2
Inpatient hospital	8.4	-1.9	14.8	18.7
Other	5.3	5.2	2.3	3.4
Surgical	29.1	34.9	31.1	28.4
Inpatient hospital	12.6	0.1	22.7	23.9
Other	16.5	34.8	8.4	4.5
Office	4.9	7.7	4.6	na
Outpatient hospital	10.9	26.3	3.6	na
Other	0.7	0.8	0.3	na
Other	41.6	46.7	42.5	34.3
Consultation	7.3	3.4	3.6	3.0
Diagnostic X-ray	10.1	10.7	9.3	6.9
Clinical laboratory	8.6	9.8	10.3	8.4
Anesthesia	2.8	2.7	4.4	4.1
Assistant at surgery	-0.1	0.5	1.3	1.9
Radiation therapy	1.5	1.5	1.2	1.2
Other	11.4	18.0	12.5	8.8

SOURCE: HCFA, BDMS, BMAD System, 1985 - 1987; Physician Summary Record System, 1975 - 1984.

Figure 5
Sources of increase in allowed Medicare charges by type of service



Prepared by the Division of Information Analysis

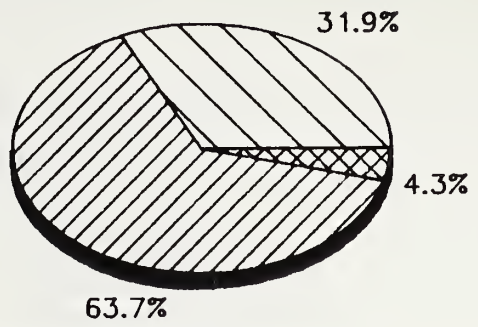
Table 10
Estimated Medicare allowed charges for physicians/suppliers by type of service for selected places of service:
Calendar years 1980 to 1987

Place and type of service	1987		1986		1985		1984		1983		1982	
	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent
	Dollars in millions											
Total	$25,556.6	100.0%	$22,085.9	100.0%	$20,015.2	100.0%	$18,376.7	100.0%	$16,979.9	100.0%	$14,631.9	100.0%
Office												
Total	8,889.5	34.8	7,509.6	34.0	6,741.0	33.7	5,816.2	31.6	5,135.2	30.2	4,412.5	30.2
Medical	4,376.4	17.1	3,727.5	16.9	3,456.3	17.3	3,053.0	16.6	2,738.7	16.1	2,403.7	16.4
Surgical	1,441.6	5.6	1,241.0	5.6	1,088.2	5.4	878.2	4.8	738.3	4.3	601.2	4.1
Diagnostic x-ray	1,056.5	4.1	851.2	3.9	775.0	3.9	635.0	3.5	554.9	3.3	471.3	3.2
Clinical laboratory	1,217.5	4.8	1,073.8	4.9	983.4	4.9	931.0	5.1	832.0	4.9	704.9	4.8
Other	797.5	3.1	616.1	2.8	438.1	2.2	319.0	1.7	271.3	1.6	231.4	1.6
Inpatient hospital												
Total	12,001.7	47.0	10,818.0	49.0	10,561.7	52.8	10,954.3	59.6	10,805.5	63.6	9,458.1	64.6
Medical	3,575.9	14.0	3,247.1	14.7	3,206.8	16.0	3,269.7	17.8	3,368.4	19.8	3,044.3	20.8
Surgical	5,046.9	19.8	4,551.5	20.6	4,463.4	22.3	4,801.1	26.1	4,546.6	26.8	3,919.2	26.8
Consultation	778.2	3.0	603.1	2.7	519.4	2.6	509.4	2.8	468.1	2.8	398.0	2.7
Diagnostic x-ray	920.4	3.6	826.0	3.7	742.3	3.7	742.5	4.0	704.9	4.2	573.2	3.9
Clinical laboratory	468.0	1.8	451.5	2.0	435.2	2.2	457.4	2.5	524.0	3.1	456.0	3.1
Anesthesia	860.2	3.4	777.2	3.5	808.6	4.0	819.3	4.5	783.7	4.6	681.5	4.7
Assistant at surgery	273.0	1.1	285.6	1.3	284.2	1.4	294.1	1.6	278.2	1.6	247.7	1.7
Other	79.1	0.3	76.0	0.3	101.8	0.5	60.8	0.3	131.6	0.8	138.2	0.9
Outpatient hospital												
Total	4,655.4	18.2	3,758.3	17.0	2,712.5	13.6	1,606.2	8.7	1,039.2	6.1	761.3	5.2
Medical	556.9	2.2	493.5	2.2	359.3	1.8	297.4	1.6	238.4	1.4	222.9	1.5
Surgical	2,550.7	10.0	2,096.4	9.5	1,526.7	7.6	735.7	4.0	382.1	2.3	228.2	1.6
Diagnostic x-ray	588.4	2.3	469.8	2.1	335.3	1.7	267.4	1.5	210.2	1.2	156.9	1.1
Clinical laboratory	188.9	0.7	164.3	0.7	122.1	0.6	94.0	0.5	68.7	0.4	53.7	0.4
Radiation therapy	159.6	0.6	131.3	0.6	118.4	0.6	101.6	0.6	86.0	0.5	62.9	0.4
Anesthesia	221.3	0.9	191.4	0.9	119.7	0.6	44.1	0.2	18.2	0.1	11.0	0.1
Other	389.6	1.5	211.6	1.0	131.0	0.7	66.0	0.4	35.6	0.2	25.7	0.2

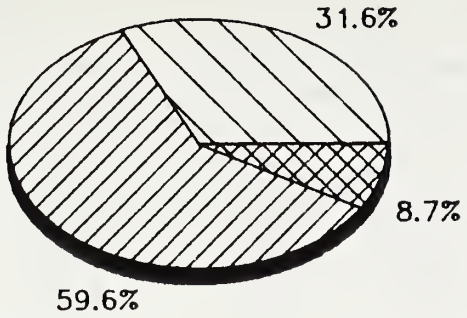
NOTE: Data for ambulatory surgical centers is included in outpatient hospital.

SOURCE: HCFA, BDMS, BMAD System, 1985 - 1987; Physician Summary Record System, 1980 - 1984.

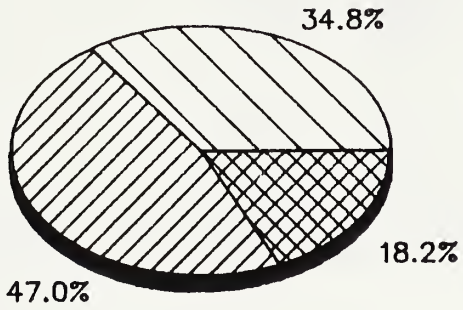
Figure 6
Allowed charges for physicians/suppliers by place of service



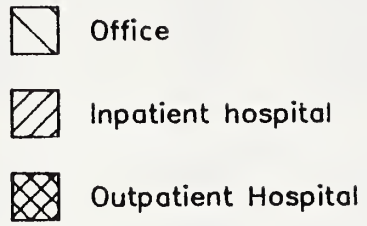
1980
$10,545.9 million



1984
$18,376.7 million



1987
$25,556.6 million



Prepared by the Division of Information Analysis

Table 11
Medicare average allowed charge per office visit and percent distribution of visits by type of visit for new and established patients: Calendar years 1985 to 1987 1/

Type of office visit	1987		1986		1985	
	Percent of visits	Average charge	Percent of visits	Average charge	Percent of visits	Average charge
New patient visits						
Total	100.0%	$41.54	100.0%	$37.37	100.0%	$34.91
Brief service	7.7	23.51	9.3	21.52	10.1	20.41
Limited service	18.8	29.40	19.9	26.79	23.6	24.68
Intermediate service	27.6	35.04	27.3	32.23	25.2	31.30
Extended service	9.7	38.70	8.5	34.26	7.7	32.31
Comprehensive service	36.4	57.44	35.0	52.32	33.4	49.80
Established patient visits						
Total	100.0	24.00	100.0	21.96	100.0	21.11
Minimal service	1.8	11.71	1.7	11.75	2.2	12.74
Brief service	11.8	16.99	13.3	15.75	14.4	15.48
Limited service	37.3	20.56	37.7	19.11	38.4	18.74
Intermediate service	37.5	25.71	36.1	23.54	34.4	22.55
Extended service	8.0	33.59	7.5	30.58	6.7	29.30
Comprehensive service	3.7	48.87	3.7	44.82	3.9	42.75
All office visits						
Total	100.0	25.26	100.0	23.09	100.0	1.47
New patient	7.2	41.54	7.3	37.37	7.5	34.91
Established patient	92.8	24.00	92.7	21.96	92.5	21.11

1/ HCPCs 90000 through 90080. Carrier local codes have been excluded from these data. Data for six Part B Carriers have been omitted from the computations in this table. See Sources and Limitations Section for further discussion.

SOURCE: HCFA, BDMS, BMAD System, Procedure File.

Table 12
Medicare average allowed charge per inpatient hospital visit and percent distribution of visits by initial care and subsequent care visits: Calendar years 1985 to 1987 1/

Type of inpatient hospital visit	1987 Percent	1987 Average charge	1986 Percent	1986 Average charge	1985 Percent	1985 Average charge
Initial care visits						
Total	100.0%	$71.23	100.0%	$65.00	100.0%	$62.25
Brief	6.7	46.12	8.0	43.28	10.2	42.52
Intermediate	23.0	60.25	23.7	55.59	23.7	54.33
Comprehensive	70.3	77.20	68.3	70.80	66.1	68.13
	100.0		100.0			
Subsequent care visits						
Total	100.0	29.25	100.0	25.88	100.0	24.81
Brief	11.0	20.50	13.4	18.73	16.2	17.97
Limited	32.4	25.93	33.6	23.55	32.9	23.01
Intermediate	40.1	30.22	38.0	26.86	37.2	26.24
Extended	9.7	39.69	8.9	35.45	8.4	34.27
Comprehensive	3.1	41.87	3.0	37.04	2.5	34.60
Discharge day management	3.6	35.92	3.2	31.66	2.6	29.95
All visits						
Total	100.0	33.37	100.0	29.98	100.0	28.54
Initial care	9.9	71.23	10.5	65.00	10.0	62.25
Subsequent care	90.1	29.25	89.5	25.88	90.0	24.81

1/ HCPCs 90200 through 90292. Carrier local codes have been excluded from these data. Data for six Part B Carriers have been omitted from the computations in this table. See Sources and Limitations Section for further discussion.

SOURCE: HCFA, BDMS, BMAD System, Procedure File.

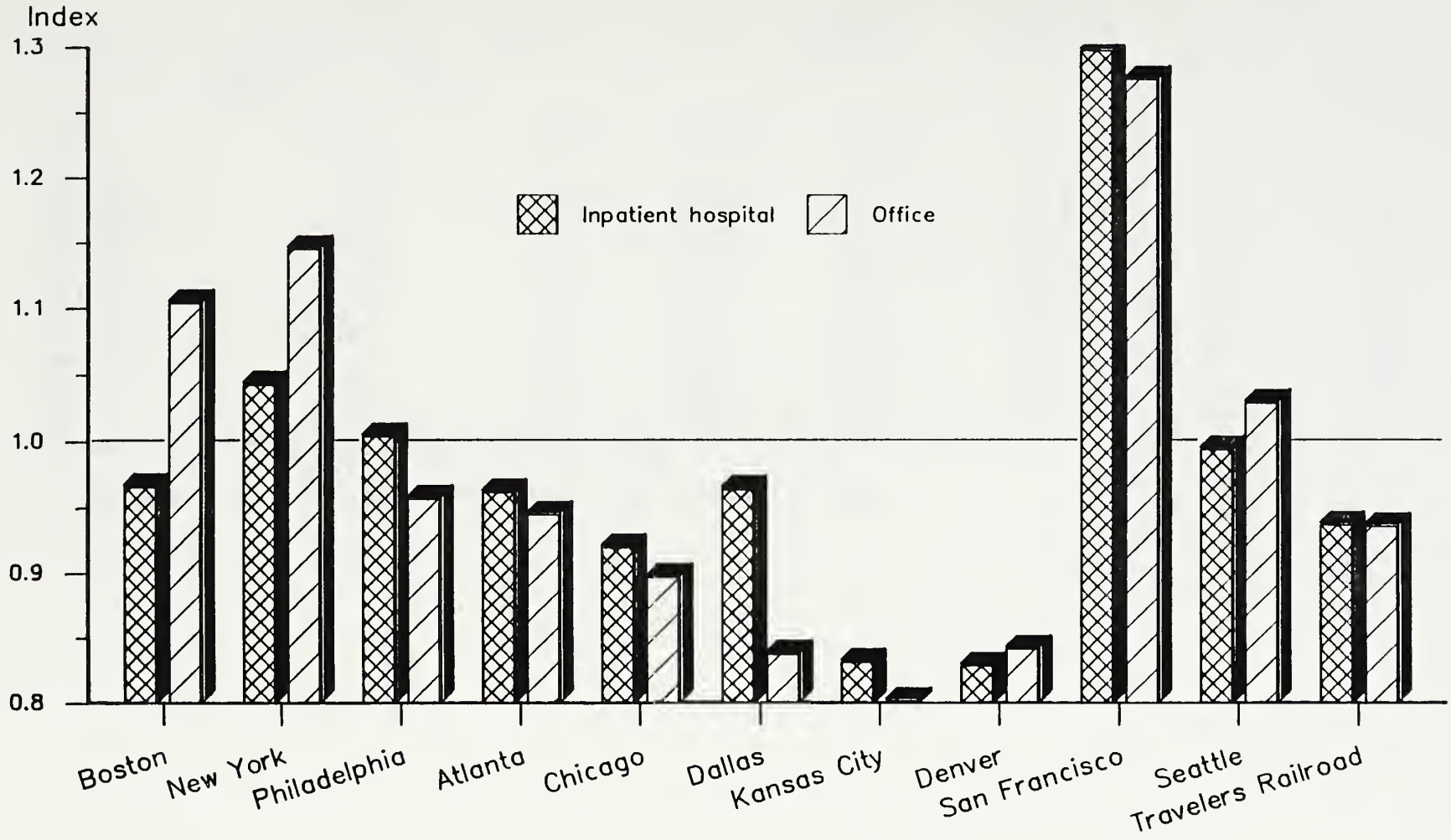
Table 13
Medicare actual and standardized inpatient and office average allowed charges per visit; index of adjusted average charges, by HCFA Region: Calendar Year 1987 1/

	Actual average		Inpatient hospital		Office	
	Inpatient hospital	Office	Standardized average price	Index	Standardized average price	Index
All Areas	$32.97	$24.81	$32.97	1.000	$24.81	1.000
Boston	30.64	27.60	31.87	0.967	27.41	1.105
New York	34.66	29.37	34.41	1.044	28.41	1.146
Philadelphia	34.43	24.83	33.12	1.005	23.76	0.958
Atlanta	32.40	23.86	31.74	0.963	23.47	0.946
Chicago	30.18	21.70	30.35	0.921	22.27	0.898
Dallas	31.05	19.80	31.81	0.965	20.83	0.839
Kansas City	26.80	18.74	27.48	0.833	19.92	0.803
Denver	26.10	19.50	27.37	0.830	20.92	0.843
San Francisco	44.29	32.32	42.77	1.297	31.63	1.275
Seattle	32.74	23.81	32.79	0.995	25.55	1.030
Travelers Railroad	30.57	22.88	30.93	0.938	23.25	0.937

1/ See page 24, Some Regional Differences, for a discussion of "standardized average price."

SOURCE: HCFA, BDMS, BMAD System, Procedure File.

Figure 7
Price indices for physician inpatient hospital and office visits by HCFA region, Calendar year 1987



Prepared by the Division of Information Analysis

Table 14
Medicare allowed physician and supplier charges by HCFA region and percent distribution of allowed charges by place of service: Calendar year 1987

Region	All places of service		Percentage distribution of allowed charges				
	Allowed charges	Percent	Total	Inpatient hospital	Outpatient facility *	Office	Other
	Dollars in millions						
Total	$30,050	100.0%	100.0%	40.3%	15.4%	29.6%	14.8%
Boston	1,533	15.1	100.0	37.4	18.5	30.0	14.2
New York	3,786	12.6	100.0	40.8	9.4	33.3	16.6
Philadelphia	3,426	11.4	100.0	42.7	14.6	27.2	15.5
Atlanta	5,740	19.1	100.0	39.6	15.3	29.2	16.0
Chicago	4,898	16.3	100.0	41.3	17.7	26.3	14.7
Dallas	2,885	9.6	100.0	43.1	17.9	27.0	12.0
Kansas City	1,202	4.0	100.0	45.0	16.8	27.4	10.7
Denver	571	1.9	100.0	38.1	17.7	28.4	15.8
San Francisco	4,447	14.8	100.0	36.9	15.1	33.6	14.3
Seattle	811	2.7	100.0	35.1	15.8	35.5	13.6
RRB	751	2.5	100.0	41.6	15.2	28.3	14.9

SOURCE: HCFA, BDMS, BMAD System, Procedure File.

* Includes charges incurred in Ambulatory Surgical Centers (ASC).

Section IV

Medicare Participating Physician and Supplier Program

- The participating physician/supplier program was originally enacted as a part of the Deficit Reduction Act (DEFRA) July 1, 1984. The number of participating arrangements reflects physicians who are participating in at least one practice setting. For example, a physician who is participating in his private practice but not in his group practice is counted as participating. Participating agents agree to accept Medicare determined reasonable charges in all their Medicare billings.

- In the latest available census, April 1988, 248 thousand physicians (37.3 percent of all physician billing arrangements) and 23 thousand non-physician suppliers (20 percent of all supplier arrangements) were participants in the program (Table 1).

- Physician participation rates vary widely by physician specialty, ranging from 32 percent of all general practice arrangements to 58 percent of all nephrology arrangements (Table 2). Suppliers of durable medical equipment and other medical supplies have the lowest participation rate of all eligible groups, less than 20 percent.

- Participation rates vary widely by geographic area, ranging from 64 percent in Alabama, to only 14 percent in Idaho (Table 3).

- Assignment rates for claims submitted to Medicare Part B carriers substantially increased after implementation of the Physician Participation Program, rising from about 53 percent in 1983 to over 76 percent in 1988 (Table 4, Figure 1).

- Medicare claim assignment rates vary widely by HCFA region (Figure 2). The highest assignment rates occur in the Boston and Philadelphia Regions. The lowest assignment rates occur in the Denver and Seattle Regions.

Table 1
Medicare participating physician and supplier program

Participation status - April 1, 1988

37.3% Physicians*	248,289	Participating
	665,425	Billing Medicare
20.3% Suppliers	22,935	Participating
	112,985	Billing Medicare

Comparison to prior enrollments

	April 1988		January 1987	May 1986	October 1985
	Number	Percent	Percent	Percent	Percent
Physicians*	248,289	37.3	30.6	28.3	28.4
Suppliers	22,935	20.3	18.6	19.0	23.0
Total	271,797	34.8	29.1	27.1	27.7

* Includes M.D.s, D.O.s, and limited license practitioners (i.e., chiropractors, podiatrist, optometrist, audiologist, psychologist, and physical therapist).

SOURCE: HCFA, BPO.

Table 2
Medicare participating physicians and suppliers
April 1988

Specialty	Participation percentage
Physicians (M.D.s and D.O.s)	
Total	37.6%
General practice	32.3
General surgery	48.5
Otology, laryngology, rhinology	36.9
Anesthesiology	25.0
Cardiovascular disease	52.8
Dermatology	45.7
Family practice	35.6
Internal medicine	41.2
Neurology	44.1
Obstetrics, gynecology	40.4
Ophthalmology	46.3
Orthopedic surgery	44.0
Pathology	48.1
Psychiatry	34.4
Radiology	46.3
Urology	41.7
Nephrology	57.8
Clinic or other group practice - not GPPP	60.8
Other physicians	24.0
Limited license practitioners (LLP)	
Total	35.6
Chiropractor	22.9
Podiatry, surgical chiropody	44.6
Optometrist	50.5
Other limited license practitioners (audiologist, psychologist, physical therapist)	33.8
Suppliers	
Total	20.3
Independent laboratory	42.0
Durable medical equipment suppliers	19.2
Ambulance service suppliers	30.0
Other suppliers	16.8

SOURCE: HCFA/BPO

Table 3
Medicare Part B participating physicians and suppliers by State 1/

States	October 1985 Percent	May 1986 Percent	January 1987 Percent	April 1988 Percent
Alabama	50.1	54.9	59.5	63.9
Physicians	58.2	63.0	68.8	73.5
Suppliers	32.2	24.8	25.8	30.1
Alaska	11.7	20.8	25.1	34.7
Physicians	10.4	22.6	27.1	37.5
Suppliers	18.1	7.3	9.1	11.7
Arizona	16.1	18.0	27.0	36.7
Physicians	15.4	18.5	28.1	38.7
Suppliers	22.7	13.7	15.2	18.2
Arkansas	41.4	33.3	39.5	47.1
Physicians	45.2	34.7	42.0	50.9
Suppliers	26.0	26.4	27.0	28.3
California	29.4	38.0	37.5	46.1
Physicians	30.0	39.7	38.9	48.5
Suppliers	24.5	25.0	20.7	27.2
Colorado	29.9	24.8	19.5	23.5
Physicians	28.1	24.4	19.5	24.9
Suppliers	38.1	26.8	19.2	15.6
Connecticut	22.9	19.7	17.8	23.0
Physicians	22.2	19.2	17.4	22.8
Suppliers	27.1	24.1	21.3	25.2
Delaware	22.6	26.2	27.4	33.8
Physicians	23.9	29.7	31.2	37.4
Suppliers	13.6	8.8	9.0	14.6
District of Columbia	29.0	24.7	26.4	31.8
Physicians	30.5	26.0	28.0	33.5
Suppliers	17.2	12.8	12.0	14.9
Florida	24.0	20.3	21.1	25.4
Physicians	25.7	22.6	24.9	30.6
Suppliers	16.5	13.6	9.6	10.9
Georgia	32.2	28.3	26.7	32.8
Physicians	33.1	27.9	25.8	32.5
Suppliers	24.6	30.4	32.0	34.3

Table 3 (continued)
Medicare Part B participating physicians and suppliers by State 1/

States	October 1985 Percent	May 1986 Percent	January 1987 Percent	April 1988 Percent
Hawaii	20.7	39.0	44.6	50.8
Physicians	20.6	41.7	47.8	53.7
Suppliers	24.5	11.4	10.2	15.7
Idaho	11.5	10.5	8.8	14.0
Physicians	11.0	10.3	10.4	14.9
Suppliers	14.8	11.4	2.0	10.4
Illinois	21.8	20.7	25.1	33.8
Physicians	23.1	21.8	26.7	36.4
Suppliers	12.2	13.7	15.1	16.8
Indiana	15.8	19.5	24.9	33.7
Physicians	18.2	21.4	26.9	36.8
Suppliers	9.1	10.0	14.6	17.8
Iowa	29.4	35.8	24.7	42.4
Physicians	29.7	38.2	25.1	43.7
Suppliers	28.7	27.4	23.5	36.8
Kansas	42.5	37.5	47.9	53.3
Physicians	45.4	39.5	51.4	60.0
Suppliers	29.4	21.8	26.6	25.8
Kentucky	24.2	25.5	32.9	39.5
Physicians	24.3	28.0	34.2	46.4
Suppliers	23.1	16.2	24.8	13.6
Louisiana	17.7	13.8	18.2	29.3
Physicians	18.8	13.4	18.1	29.5
Suppliers	12.0	16.5	19.6	27.3
Maine	33.1	27.1	32.6	39.5
Physicians	35.4	28.5	34.2	42.4
Suppliers	27.7	20.3	25.1	26.7
Maryland	30.5	28.0	28.8	36.6
Physicians	30.4	28.5	30.1	38.5
Suppliers	30.7	24.9	20.1	22.8
Massachusetts	47.2	42.1	41.9	43.4
Physicians	48.1	43.0	43.8	45.9
Suppliers	43.6	36.5	29.4	27.0

Table 3 (continued)
Medicare Part B participating physicians and suppliers by State 1/

States	October 1985 Percent	May 1986 Percent	January 1987 Percent	April 1988 Percent
Michigan	42.3	35.3	31.1	36.5
Physicians	44.0	37.1	32.7	38.3
Suppliers	26.8	22.6	19.7	23.3
Minnesota	19.2	19.9	21.5	23.9
Physicians	18.5	20.7	22.4	25.4
Suppliers	24.3	15.7	16.8	16.0
Mississippi	21.2	20.8	21.4	28.5
Physicians	19.1	22.8	23.6	30.1
Suppliers	30.0	14.8	14.4	23.8
Missouri	32.7	23.1	23.6	27.9
Physicians	35.2	24.0	24.5	29.5
Suppliers	17.7	16.0	14.9	16.0
Montana	22.1	13.2	15.5	17.5
Physicians	24.3	13.9	17.0	19.9
Suppliers	17.0	11.2	11.3	10.8
Nebraska	21.3	22.1	24.5	40.6
Physicians	20.0	23.8	25.7	48.2
Suppliers	24.2	19.3	22.0	23.8
Nevada	20.4	25.4	32.0	43.6
Physicians	21.7	26.8	33.5	46.0
Suppliers	11.9	11.7	15.7	20.2
New Hampshire	29.5	26.7	25.4	27.7
Physicians	26.9	27.2	25.9	28.4
Suppliers	39.2	24.0	23.0	24.1
New Jersey	18.2	20.2	22.1	27.1
Physicians	18.0	20.6	22.7	28.2
Suppliers	19.0	18.5	18.9	21.6
New Mexico	18.4	14.3	20.9	23.7
Physicians	17.7	13.8	20.8	25.9
Suppliers	21.9	18.2	21.4	14.0
New York	21.6	20.3	24.5	28.1
Physicians	20.8	19.9	24.1	28.4
Suppliers	27.4	23.9	28.4	25.0

Table 3 (continued)
Medicare Part B participating physicians and suppliers by State 1/

States	October 1985 Percent	May 1986 Percent	January 1987 Percent	April 1988 Percent
North Carolina	36.9	31.5	28.3	36.1
Physicians	39.1	34.3	31.4	40.7
Suppliers	19.5	16.2	12.8	13.2
North Dakota	13.0	13.4	17.6	26.6
Physicians	10.9	13.8	20.5	30.8
Suppliers	19.4	12.2	11.4	16.2
Ohio	21.3	25.0	27.5	38.4
Physicians	21.7	26.4	28.9	41.8
Suppliers	18.4	18.2	19.2	18.7
Oklahoma	14.1	14.5	17.9	24.2
Physicians	13.8	16.6	20.8	27.9
Suppliers	17.2	7.1	7.4	11.2
Oregon	18.7	21.3	24.4	30.6
Physicians	18.5	22.8	26.1	32.8
Suppliers	19.3	12.6	13.8	15.5
Pennsylvania	47.2	42.7	35.6	34.9
Physicians	50.8	45.6	32.1	36.6
Suppliers	26.9	24.3	19.5	23.2
Rhode Island	43.0	43.2	45.1	48.8
Physicians	46.7	48.1	50.8	55.0
Suppliers	24.0	19.2	15.5	15.5
South Carolina	17.3	15.6	22.7	36.1
Physicians	17.9	16.8	25.3	37.6
Suppliers	9.3	9.6	11.0	22.4
South Dakota	10.3	8.9	12.2	16.3
Physicians	8.0	6.9	12.7	17.6
Suppliers	15.3	12.0	11.3	13.9
Tennessee	22.3	34.2*	39.4	48.8
Physicians	21.1	37.4*	43.4	54.9
Suppliers	28.2	19.5*	20.7	20.6
Texas	19.5	13.5	18.3	24.3
Physicians	19.7	14.1	19.4	26.0
Suppliers	17.6	9.4	10.3	12.7

Table 3 (continued)
Medicare Part B participating physicians and suppliers by State 1/

States	October 1985 Percent	May 1986 Percent	January 1987 Percent	April 1988 Percent
Utah	29.1	34.0	39.8	48.7
Physicians	29.3	36.1	42.2	50.4
Suppliers	28.2	21.0	23.8	26.4
Vermont	40.2	37.6	33.6	37.6
Physicians	41.5	38.2	34.1	38.5
Suppliers	35.7	32.9	29.4	30.7
Virginia	28.2	28.6	32.4	37.2
Physicians	29.6	29.5	33.6	39.1
Suppliers	19.2	21.4	22.6	21.7
Washington	23.0	22.1	27.0	33.2
Physicians	23.6	21.8	26.9	35.4
Suppliers	19.0	25.1	27.7	18.8
West Virginia	22.2	30.8	35.0	48.1
Physicians	22.9	33.0	37.5	53.2
Suppliers	17.9	21.4	23.7	24.7
Wisconsin	30.3	37.3	35.8	38.6
Physicians	31.0	37.5	35.1	39.0
Suppliers	26.5	36.9*	38.0	37.5
Wyoming	18.8	15.8	18.1	18.1
Physicians	18.3	16.9	20.3	20.1
Suppliers	21.8	12.2	11.3	12.6

1/ Includes M.D.s, D.O.s, and limited license practitioners.
* Based on revised data submitted by the carrier. (Previously submitted 26.4)

SOURCE: HCFA, BPO.

Table 4
Medicare assigned claims:
Fiscal years 1975 to 1988

Fiscal year	Gross assignme rate 1
1988	76.3%
1987	71.7
1986	68.0
1985	67.7
1984	56.7
1983	55.7
1982	55.2
1981	54.8
1980	54.1
1979	53.9
1978	53.8
1977	54.1
1976	55.1
1975	55.9

1/ For years 1975 through 1984 includes data from physic billing forms 1490, 1554 (hospital based physicians), and 1556 (group practice prepayment plans). After 19 and the elimination of hospital based billing, includ data from form 1500 (all physicians/suppliers and gro practice prepayment plans).

SOURCE: HCFA/BPO.

Figure 1
Medicare physician/supplier gross assignment rates
Fiscal years 1975 to 1988

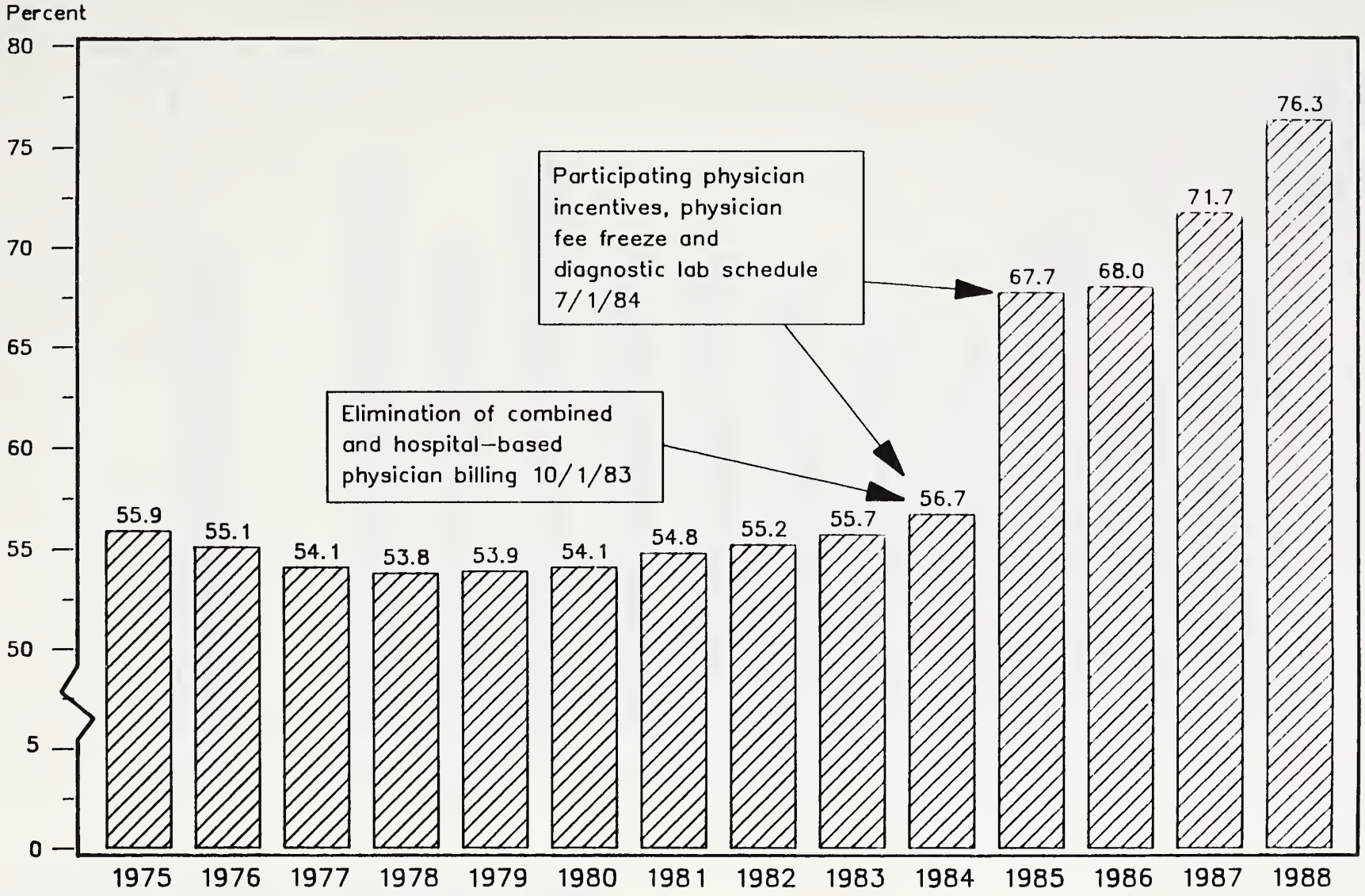


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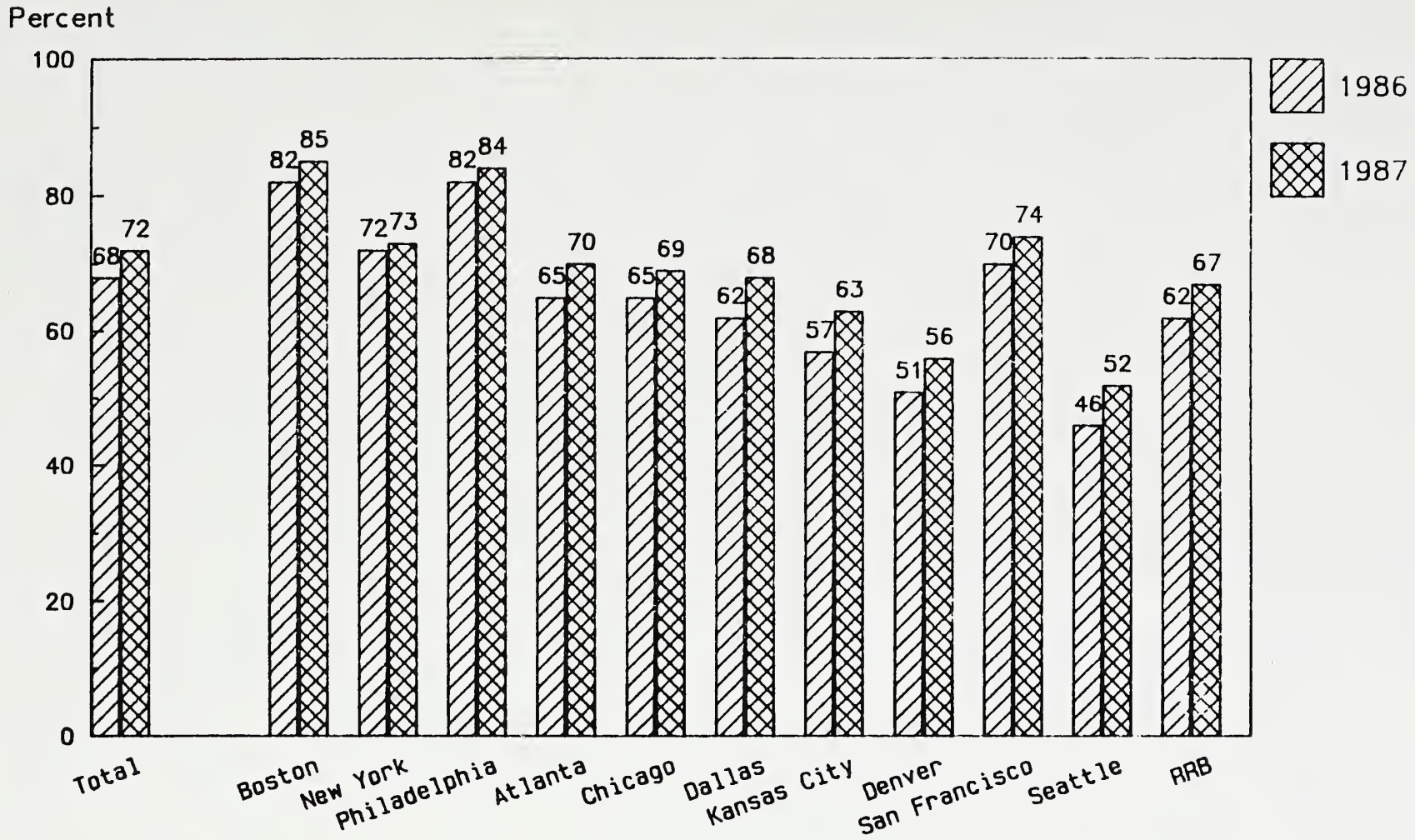
Figure 2
Medicare assignment rates by region, Fiscal year 1986 vs 1987



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Section V

Physician and Non-institutional Supplier Charges by Procedure, 1987

- More than ten thousand different procedure codes are available to physicians/suppliers for billing Part B services. However, relative few codes account for the bulk of total billings. In 1987, billings under 98 procedure codes accounted for $16.2 billion in allowed charges, about 56 percent of all allowed charges processed by Part B carrier in the year which were reported in HCFA's Part B Carrier BMAD System. Five top procedures account for 17 percent of all charges (Table 1, Figure 1). Procedures are ranked in Table 1 by their total contribution to allowed charges.

- In Tables 2 through 6, allowed charges for 400 separate procedure codes are categorized by place and by type of service and ranked in importance based on their contribution to allowed charges. Only procedures which contribute more than $10 million to a particular place and service combination are listed in Tables 2 through 6. Collectively the 400 procedures contributed about 64 percent of all allowed charges processed by Part B Carriers in 1987. (Data for Carriers who continued to use local coding schemes were omitted from these tables. The amount omitted was $180 million.)

- The highest dollar volume for office services are represented by medical type of service, particularly office visit procedures (Table 2).

- The highest dollar volume for inpatient services are represented by medical type of service, particularly hospital visit procedures (Table 3). Significant dollar amounts for inpatient services are also observed for a wide variety of surgical procedures, a limited number of consultation procedures and other ancillary services.

- Surgical procedures, particularly for cataract conditions and endoscopies, dominate the outpatient facility place of service (Table 4). Services provided in Ambulatory Surgical Centers are included in this Table.

- Automated multichannel tests are the largest single source of allowed charges in independent laboratories (Table 5).

- "Other" places of service (Table 6) include services in homes, nursing homes and other unspecified places. Significant contributions to allowed charges are displayed for durable medical equipment (primarily oxygen related), and ambulance services.

- Some procedures in Tables 2 through 6 may appear more than once in a table because different types of service are reported under the same procedure code. For example, procedure code 66984, Remove Cataract, Insert Lens, appears in Table 4 (Outpatient place of service) under types of service "surgery," "anesthesia," and "assistant-at-surgery." Other procedures in these tables may appear more than once in a table although they may represent the same type of service due to variation in Part B Carrier reporting practices. For example, procedure code 93000, ECG with Report, appears in Table 2 under Types of service "Diagnostic lab" and "Other."

Table 1
Medicare leading procedure codes based on allowed charges: 1/
Calendar year 1987

Procedure code		Allowed charges	Percent of total allowed charges 2/
All procedure codes 3/		$28,890,217,000	100.0%
Leading procedure codes		$16,247,087,968	56.2
66984	REMOVE CATARACT, INSERT LENS	1,582,050,892	5.5
90060	OFFICE VISIT,INTERMEDIATE	1,034,715,848	3.6
90260	HOSPITAL VISIT, INTERMEDIATE	878,996,700	3.0
90050	OFFICE VISIT, LIMITED	858,936,883	3.0
90250	HOSPITAL VISIT, LIMITED	604,384,990	2.1
90620	COMPREHENSIVE CONSULTATION	447,926,010	1.6
90220	HOSPITAL CARE, NEW, COMPREHENSIVE	437,401,231	1.5
52601	PROSTATECTOMY (TUR)	332,203,279	1.1
93000	ECG, WITH REPORT	329,639,534	1.1
71020	X-RAY EXAM OF CHEST	318,624,575	1.1
90070	OFFICE VISIT EXTENDED	283,208,835	1.0
A0010	AMBULANCE SERVICE, BASIC LIFE SUPPORT	272,401,014	0.9
90270	HOSPITAL VISIT, EXTENDED	267,589,313	0.9
E1396	OXYGEN CONCENTRATOR, EQUIV. TO OVER 1952	257,495,841	0.9
90040	OFFICE VISIT, BRIEF	222,180,815	0.8
93010	ECG REPORT ONLY	205,088,007	0.7
33512	CORONARY ARTERY BYPASS, 3 GRAFTS	195,661,324	0.7
90080	OFFICE VISIT,COMPREHENSIVE	190,183,096	0.7
27130	TOTAL HIP JOINT REPLACEMENT	188,339,283	0.7
27447	TOTAL KNEE REPLACEMENT	179,736,096	0.6
90020	OFFICE VISIT, NEW, COMPREHENSIVE	172,984,974	0.6
66983	REMOVE CATARACT, INSERT LENS	171,876,120	0.6
33513	CORONARY ARTERY BYPASS, 4 GRAFTS	167,825,544	0.6
71010	X-RAY EXAM OF CHEST	162,459,434	0.6
90240	HOSPITAL VISIT, BRIEF	161,643,283	0.6

Table 1 (continued)
Medicare leading procedure codes based on allowed charges: 1/
Calendar year 1987

Procedure code		Allowed charges	Percent of total allowed charges 2/
E0410	OXYGEN CONTENTS, LIQUID, PER POUND	151,585,872	0.5
92014	EYE EXAM & TREATMENT	151,266,036	0.5
43235	UPPER GI ENDOSCOPY,DIAGNOSIS	150,536,140	0.5
90630	COMPLEX CONSULTATION	149,809,841	0.5
93547	HEART CATHETER & ANGIOGRAM	140,511,073	0.5
45378	DIAGNOSTIC COLONOSCOPY	137,999,608	0.5
80019	AUTOMATED MULTICHANNEL TEST	135,976,141	0.5
A2000	MANIPULATION OF SPINE BY CHIROPRACTOR	132,023,198	0.5
66821	LASERING, SECONDARY CATARACT	129,754,507	0.4
27244	REPAIR OF FEMUR FRACTURE	126,531,604	0.4
45385	COLONOSCOPY, LESION REMOVAL	122,058,612	0.4
92012	EYE EXAM & TREATMENT	116,674,440	0.4
35301	RECHANNELING OF ARTERY	114,011,554	0.4
44140	PARTIAL REMOVAL OF COLON	110,253,583	0.4
90215	HOSPITAL CARE,NEW, INTERMEDIATE	109,649,558	0.4
99173	CRITICAL CARE, FOLLOW-UP	106,798,663	0.4
90280	HOSPITAL VISIT,COMPREHENSIVE	106,295,420	0.4
93549	HEART CATHETER & ANGIOGRAM	101,418,099	0.4
43239	UPPER GI ENDOSCOPY, BIOPSY	99,236,122	0.3
70470	CONTRAST CAT SCANS OF HEAD	98,395,723	0.3
88304	SURGICAL PATHOLOGY, COMPLETE	97,566,452	0.3
27236	REPAIR OF FEMUR FRACTURE	96,614,341	0.3
90844	INDIVIDUAL PSYCHOTHERAPY	93,701,052	0.3
90292	HOSPITAL DISCHARGE DAY	92,208,206	0.3
70450	CAT SCAN OF HEAD OR BRAIN	91,687,810	0.3
45330	SIGMOIDOSCOPY	90,779,965	0.3
88305	SURGICAL PATHOLOGY, COMPLETE	90,630,392	0.3
77410	DAILY RADIATION THERAPY	88,888,900	0.3
99160	CRITICAL CARE, EACH HOUR	87,924,601	0.3
47605	REMOVAL OF GALLBLADDER	86,131,269	0.3

Table 1 (continued)
Medicare leading procedure codes based on allowed charges: 1/
Calendar year 1987

Procedure code		Allowed charges	Percent of total allowed charges 2/
76091	X-RAY EXAM OF BREASTS	85,962,731	0.3
67228	TREATMENT OF RETINAL LESION	84,868,460	0.3
A0020	AMBULANCE SERVICE, (BLS) LIFE SUPPORT	84,210,532	0.3
90015	OFFICE VISIT, NEW, INTERMEDIATE	83,276,299	0.3
90515	EMERGENCY CARE, NEW,INTERMEDIATE	82,422,296	0.3
33511	CORONARY ARTERY BYPASS, 2 GRAFTS	81,584,142	0.3
92982	CORONARY ARTERY DILATION	79,143,509	0.3
93870	CAROTID ARTERY IMAGING	78,954,090	0.3
52000	CYSTOSCOPY	78,573,001	0.3
76516	ECHO EXAM OF EYE	78,046,636	0.3
49505	REPAIR INGUINAL HERNIA	77,935,361	0.3
90610	EXTENDED CONSULTATION	75,745,850	0.3
93262	ECG MONITORING, 12-24 HOURS	75,539,175	0.3
81000	URINALYSIS, WITH MICRSCOPY	73,652,812	0.3
90517	EMERGENCY CARE, NEW, EXTENDED	73,080,446	0.3
A0220	AMBULANCE SERV., ADVANCED LIFE SUPPORT	72,810,822	0.3
93015	CARDIOVASCULAR STRESS TEST	72,556,932	0.3
65855	LASER SURGERY OF EYE	71,588,065	0.2
99174	CRITICAL CARE, FOLLOW-UP	69,333,840	0.2
33514	CORONARY ARTERY BYPASS, 5 GRAFTS	68,601,173	0.2
V2632	POSTERIOR CHAMBER IOL	67,755,372	0.2
74160	CONTRAST CAT SCAN OF ABDOMEN	67,749,130	0.2
77405	DAILY RADIATION THERAPY	66,246,773	0.2
93309	ECHO EXAM OF HEART	66,117,218	0.2
M0945	OUTPATIENT DIALYSIS RELATED PHYSICIAN	66,005,984	0.2
92004	NEW EYE EXAM & TREATMENT	65,769,558	0.2
19240	EXTENSIVE BREAST SURGERY	63,023,138	0.2
B4150	ENTERAL FORMULAE; CATEGORY I	62,729,559	0.2
B4035	ENTERAL FEEDING SUPPLY KIT;-PUMP MONTHLY	62,169,335	0.2
76700	ECHO EXAM OF ABDOMEN	61,195,650	0.2

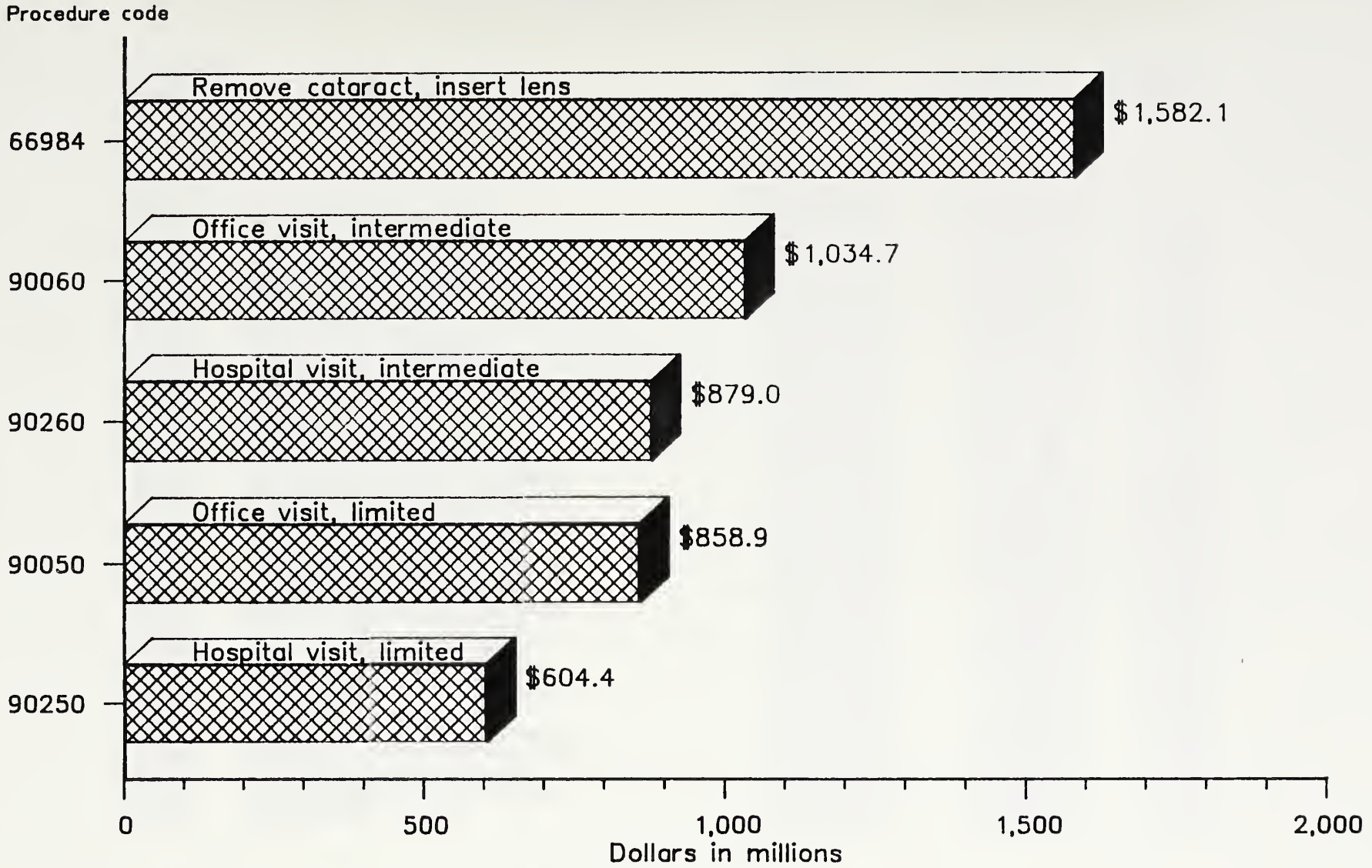
Table 1 (continued)
Medicare leading procedure codes based on allowed charges: 1/
Calendar year 1987

Procedure code		Allowed charges	Percent of total allowed charges 2/
36415	COLLECTION OF VENOUS BLOOD	60,653,037	0.2
E0620	SEAT LIFT CHAIR, MOTORIZED	59,791,638	0.2
45380	COLONOSCOPY AND BIOPSY	59,754,809	0.2
90843	INDIVIDUAL PSYCHOTHERAPY	58,463,939	0.2
93503	RIGHT HEART CATHETERIZATION	56,976,582	0.2
47600	REMOVAL OF GALLBLADDER	55,762,361	0.2
E0260	HOSPITAL BED, W/SIDE RAILS SEMI ELECTRIC	54,699,989	0.2
E0265	HOSPITAL BED, TOTAL ELECTRIC W/SIDE RAILS	54,534,652	0.2
E0255	HOSPITAL BED, W/SIDE RAILS VARIABLE HEIGHT	53,572,611	0.2
85022	BLOOD COUNT, HEMOGRAM	52,662,619	0.2
35081	REPAIR DEFECT OF ARTERY	52,006,781	0.2
90605	INTERMEDIATE CONSULTATION	50,758,630	0.2
78306	NUCLEAR SCAN OF SKELETON	50,330,728	0.2
Procedure codes not shown		$12,643,129,032	43.8

1/ Some procedure codes include dollars for more than just physicians services (E.G., 66984 may include dollars for the physician, the assistant-at-surgery and the anesthesiologist).
2/ Allowed charges are shown as a percent of all physician and supplier allowed charges submitted to Part B carriers. Total allowed charges shown have not been inflated for missing data and do not include local codes.
3/ Allowed charges were aggregated by procedure code and those over $50 million were retained for analysis, a total of 98 procedure codes.

SOURCE: HCFA, BDMS, BMAD System, Procedure File.

Figure 1
Medicare top five procedure codes based on allowed charges, Calendar year 1987



Prepared by the Division of Information Analysis

Table 2
Medicare leading procedure codes based on allowed charges by type of service with place of service office:
Calendar year 1987

Procedure code	Description	Allowed charges	Allowed services	Average charge
Medical care				
ALL		$3,660,676,290	145,298,729	
90060	OFFICE VISIT,INTERMEDIATE	1,028,196,838	40,612,281	$25.32
90050	OFFICE VISIT, LIMITED	851,606,158	41,755,214	20.40
90070	OFFICE VISIT EXTENDED	281,361,300	8,539,402	32.95
90040	OFFICE VISIT, BRIEF	219,241,293	12,831,920	17.09
90080	OFFICE VISIT,COMPREHENSIVE	188,592,440	3,926,144	48.04
90020	OFFICE VISIT, NEW, COMPREHENSIVE	170,992,029	3,041,651	56.22
92014	EYE EXAM & TREATMENT	144,437,276	3,648,124	39.59
A2000	MANIPULATION OF SPINE BY CHIROPRACTOR	121,233,125	7,370,199	16.45
92012	EYE EXAM & TREATMENT	109,572,151	3,624,590	30.23
90015	OFFICE VISIT, NEW, INTERMEDIATE	81,976,804	2,375,122	34.51
93000	ECG, WITH REPORT	65,130,676	1,862,381	34.97
92004	NEW EYE EXAM & TREATMENT	61,635,776	1,491,301	41.33
90010	OFFICE VISIT, NEW, LIMITED	44,745,597	1,539,983	29.06
90017	OFFICE VISIT, NEW, EXTENDED	31,295,573	810,520	38.61
92235	OPHTHALMOSCOPY/ANGIOGRAPHY	29,897,137	246,109	121.48
90844	INDIVIDUAL PSYCHOTHERAPY	25,513,603	650,487	39.22
90030	OFFICE VISIT, MINIMAL	23,330,672	1,979,171	11.79
92083	VISUAL FIELD EXAMINATION(S)	20,823,558	355,366	58.60
90843	INDIVIDUAL PSYCHOTHERAPY	18,214,874	757,171	24.06
93262	ECG MONITORING, 12-24 HOURS	17,844,677	76,784	232.40
92002	NEW EYE EXAM & TREATMENT	15,439,763	443,123	34.84
90000	OFFICE VISIT, NEW, BRIEF	14,364,202	612,366	23.46
92286	INTERNAL EYE PHOTOGRAPHY	13,628,491	143,640	94.88
93015	CARDIOVASCULAR STRESS TEST	13,334,381	93,338	142.86
97110	THERAPEUTIC EXERCISES	12,925,499	763,298	16.93
92082	VISUAL FIELD EXAMINATION(S)	12,564,476	362,994	34.61
92225	EXTENDED OPHTHALMOSCOPY, NEW	11,059,622	328,453	33.67
92557	COMPREHENSIVE AUDIOMETRY	10,730,721	251,249	42.71
36415	COLLECTION OF VENOUS BLOOD	10,629,412	3,523,678	3.02
97128	ULTRASOUND THERAPY	10,358,166	818,546	12.65

Table 2 (continued)
Medicare leading procedure codes based on allowed charges by type of service with place of service office:
Calendar year 1987

Procedure code	Description	Allowed charges	Allowed services	Average charge
Surgery				
ALL		$670,789,481	9,107,827	
45330	SIGMOIDOSCOPY	58,924,892	492,465	$119.65
66821	LASERING, SECONDARY CATARACT	53,035,996	107,635	492.74
67228	TREATMENT OF RETINAL LESION	49,466,971	62,853	787.03
66984	REMOVE CATARACT, INSERT LENS	45,650,469	31,233	1,461.61
17000	DESTRUCTION OF FACE LESION	41,167,442	1,263,798	32.57
52000	CYSTOSCOPY	39,876,631	391,687	101.81
20610	INJECT/DRAIN JOINT/BURSA	35,679,351	1,199,503	29.75
65855	LASER SURGERY OF EYE	33,404,653	37,880	881.85
11642	REMOVAL OF SKIN LESION	27,703,735	139,491	198.61
11100	BIOPSY OF LESION	24,689,827	585,747	42.15
11641	REMOVAL OF SKIN LESION	22,454,737	143,366	156.63
11750	REMOVAL OF NAIL BED	21,889,762	166,985	131.09
67210	TREATMENT OF RETINAL LESION	19,308,719	25,041	771.08
45378	DIAGNOSTIC COLONOSCOPY	19,126,563	46,920	407.64
43235	UPPER GI ENDOSCOPY,DIAGNOSIS	17,252,790	54,301	317.73
17100	DESTRUCTION OF SKIN LESION	16,848,134	648,138	25.99
17001	DESTRUCTION OF ADDED LESIONS	16,356,830	1,051,722	15.55
45300	PROCTOSIGMOIDOSCOPY	16,252,215	379,778	42.79
45385	COLONOSCOPY, LESION REMOVAL	14,698,402	21,730	676.41
66761	REVISION OF IRIS	11,824,919	18,318	645.54
20550	INJECTION TREATMENT	11,392,228	462,130	24.65
43239	UPPER GI ENDOSCOPY, BIOPSY	10,768,604	30,154	357.12
11640	REMOVAL OF SKIN LESION	10,768,168	86,567	124.39
11710	SURGICAL CLEANSING OF NAILS	10,758,822	484,860	22.19
11441	REMOVAL OF SKIN LESION	10,544,512	173,900	60.64
10060	DRAINAGE OF SKIN ABSCESS	10,411,046	331,028	31.45
11000	SURGICAL CLEANSING OF SKIN	10,383,853	360,344	28.82
11730	REMOVAL OF NAIL PLATE	10,149,210	310,253	32.71

Table 2 (continued)
Medicare leading procedure codes based on allowed charges by type of service with place of service office:
Calendar year 1987

Procedure code	Description	Allowed charges	Allowed services	Average charge
Consultation				
ALL		$195,181,232	2,664,079	
90620	COMPREHENSIVE CONSULTATION	99,055,767	1,079,629	$91.75
90630	COMPLEX CONSULTATION	33,978,701	274,959	123.58
90610	EXTENDED CONSULTATION	22,560,284	339,776	66.40
90605	INTERMEDIATE CONSULTATION	14,739,333	286,119	51.51
90600	LIMITED CONSULTATION	13,623,804	319,089	42.70
93000	ECG, WITH REPORT	11,223,343	364,507	30.79
Diagnostic xray				
ALL		$608,843,427	10,682,086	
71020	X-RAY EXAM OF CHEST	162,745,613	4,365,505	$37.28
76091	X-RAY EXAM OF BREASTS	60,040,880	779,857	76.99
70551	MAGNETIC IMAGE, BRAIN	33,929,803	56,817	597.18
71010	X-RAY EXAM OF CHEST	27,965,370	1,060,940	26.36
70470	CONTRAST CAT SCANS OF HEAD	23,922,980	70,937	337.24
72110	X-RAY EXAM OF LOWER SPINE	23,832,053	359,806	66.24
73510	X-RAY EXAM OF HIP	22,928,639	565,241	40.56
73560	X-RAY EXAM OF KNEE	17,892,482	590,182	30.32
74160	CONTRAST CAT SCAN OF ABDOMEN	17,144,226	50,852	337.14
73620	X-RAY EXAM OF FOOT	16,988,549	580,668	29.26
74270	CONTRAST X-RAY EXAM OF COLON	16,831,307	209,685	80.27
73630	X-RAY EXAM OF FOOT	16,308,058	453,028	36.00
72100	X-RAY EXAM OF LOWER SPINE	16,050,720	360,818	44.48
70450	CAT SCAN OF HEAD OR BRAIN	15,306,587	63,296	241.83
74280	CONTRAST X-RAY EXAM OF COLON	15,131,857	145,780	103.80
76516	ECHO EXAM OF EYE	14,769,555	104,891	140.81
73030	X-RAY EXAM OF SHOULDER	13,724,687	378,087	36.30

Table 2 (continued)
Medicare leading procedure codes based on allowed charges by type of service with place of service office:
Calendar year 1987

Procedure code	Description	Allowed charges	Allowed services	Average charge
72131	CAT SCAN OF LOWER SPINE	13,360,519	40,080	333.35
74170	CONTRAST CAT SCANS, ABDOMEN	12,970,037	33,137	391.41
72141	MRI, SPINAL CHORD, CERVICAL	12,187,230	18,922	644.08
74240	X-RAY EXAM UPPER GI TRACT	12,099,783	145,666	83.07
93870	CAROTID ARTERY IMAGING	11,625,737	58,133	199.99
74400	CONTRAST X-RAY URINARY TRACT	10,445,612	119,927	87.10
78306	NUCLEAR SCAN OF SKELETON	10,358,274	53,741	192.74
72144	MAGNETIC RESONANCE IMAGING	10,282,869	16,090	639.08
Diagnostic lab				
ALL		$736,578,852	43,743,450	
93000	ECG, WITH REPORT	190,689,362	5,535,272	$34.45
76516	ECHO EXAM OF EYE	59,960,744	420,050	142.75
81000	URINALYSIS, WITH MICRSCOPY	57,905,122	10,762,898	5.38
93015	CARDIOVASCULAR STRESS TEST	41,063,053	285,307	143.93
82947	GLUCOSE, EXCEPT URINE	33,326,526	5,081,060	6.56
76519	ECHO EXAM OF EYE	26,710,022	184,906	144.45
93262	ECG MONITORING, 12-24 HOURS	26,227,340	120,180	218.23
Q0019	ELECTROCARDIOGRAPHIC MONITORING	25,742,156	114,880	224.08
88304	SURGICAL PATHOLOGY, COMPLETE	25,347,932	785,459	32.27
36415	COLLECTION OF VENOUS BLOOD	22,708,044	7,628,370	2.98
85022	BLOOD COUNT, HEMOGRAM	22,441,261	2,362,307	9.50
85031	BLOOD COUNT, COMPLETE CBC	19,470,244	2,081,704	9.35
93870	CAROTID ARTERY IMAGING	19,317,137	103,401	186.82
76700	ECHO EXAM OF ABDOMEN	18,616,134	132,587	140.41
93309	ECHO EXAM OF HEART	17,875,016	79,537	224.74
93263	ECG MONITORING, 12-24 HOURS	13,047,432	59,662	218.69
80019	AUTOMATED MULTICHANNEL TEST	12,667,727	683,470	18.53

Table 2 (continued)
Medicare leading procedure codes based on allowed charges by type of service with place of service office:
Calendar year 1987

Procedure code	Description	Allowed charges	Allowed services	Average charge
76629	ECHO EXAM OF HEART	12,428,369	55,472	224.05
76512	ECHO EXAM OF EYE	12,412,118	69,611	178.31
82270	BLOOD, OCCULT	12,305,565	3,311,265	3.72
84132	POTASSIUM BLOOD TEST	12,037,043	1,707,157	7.05
93910	LOWER LIMB ARTERY STUDY	11,892,572	101,460	117.21
85021	BLOOD COUNT, HEMOGRAM, AUTOMATED	10,870,017	1,323,102	8.22
80016	AUTOMATED MULTICHANNEL TEST	10,683,222	615,267	17.36
76627	ECHO EXAM OF HEART	10,562,237	56,200	187.94
76511	ECHO EXAM OF EYE	10,272,457	82,866	123.96
Radiation therapy				
ALL		$79,961,393	992,376	
77410	DAILY RADIATION THERAPY	40,235,372	419,884	$95.82
77405	DAILY RADIATION THERAPY	25,202,591	326,276	77.24
77400	DAILY RADIATION THERAPY	14,523,430	246,216	58.99
Other medical services				
ALL		$100,073,949	2,700,779	
93000	ECG, WITH REPORT	53,151,810	1,414,704	$37.57
V2020	FRAMES PURCHASE	13,679,411	314,634	43.48
93262	ECG MONITORING, 12-24 HOURS	11,518,689	51,024	225.75
V2203	SPHEREOCYLINDER FIFOCAL	11,084,553	323,483	34.27
A4550	SURGICAL TRAYS	10,639,486	596,934	17.82

SOURCE: HCFA, BDMS, BMAD System, Procedure File.

Table 3
Medicare leading procedure codes based on allowed charges by type of service with place of service inpatient:
Calendar year 1987

Procedure code	Description	Allowed charges	Allowed services	Average charge
Medical care				
ALL		$3,345,738,712	94,900,551	
90260	HOSPITAL VISIT, INTERMEDIATE	878,492,418	29,753,713	$29.53
90250	HOSPITAL VISIT, LIMITED	603,920,293	23,493,591	25.71
90220	HOSPITAL CARE, NEW, COMPREHENSIVE	435,641,548	5,646,572	77.15
90270	HOSPITAL VISIT, EXTENDED	267,432,196	6,898,027	38.77
90240	HOSPITAL VISIT, BRIEF	161,498,971	8,010,999	20.16
90215	HOSPITAL CARE,NEW, INTERMEDIATE	108,720,895	1,799,243	60.43
99173	CRITICAL CARE, FOLLOW-UP	106,308,916	2,200,297	48.32
90280	HOSPITAL VISIT,COMPREHENSIVE	106,205,022	2,511,405	42.29
90292	HOSPITAL DISCHARGE DAY	92,014,663	2,619,671	35.12
99160	CRITICAL CARE, EACH HOUR	73,295,881	844,532	86.79
99174	CRITICAL CARE, FOLLOW-UP	69,033,790	1,167,635	59.12
90844	INDIVIDUAL PSYCHOTHERAPY	60,054,831	885,229	67.84
99172	CRITICAL CARE, FOLLOW-UP	42,826,966	1,007,543	42.51
93547	HEART CATHETER & ANGIOGRAM	35,944,300	53,558	671.13
93010	ECG REPORT ONLY	34,113,130	3,081,387	11.07
90843	INDIVIDUAL PSYCHOTHERAPY	31,930,792	816,583	39.10
99171	CRITICAL CARE, FOLLOW-UP	30,559,488	817,723	37.37
90200	HOSPITAL CARE, NEW, BRIEF	24,022,031	520,721	46.13
M0022	ICU FOLLOWUP CARE	20,836,115	380,823	54.71
M0021	INPATIENT HOSP CARE, PER DIEM	19,115,416	764,832	24.99
92982	CORONARY ARTERY DILATION	18,826,041	13,886	1,355.76
90941	HEMODIALYSIS, INITIAL/ACUTE	18,663,875	79,989	233.33
90841	INDIVIDUAL PSYCHOTHERAPY	16,267,626	346,326	46.97
93549	HEART CATHETER & ANGIOGRAM	15,296,978	17,428	877.72
99154	MGT OF DRUG ADMIN	13,577,802	387,993	34.99
99162	CRITICAL CARE, ADDED 30 MIN	13,513,266	311,866	43.33
94657	CONTINUED VENTILATION ASSIST	12,409,069	236,121	52.55
90955	HEMODIALYSIS, MAINTENANCE	11,982,363	115,619	103.64
93503	RIGHT HEART CATHETERIZATION	11,865,264	39,843	297.80
90951	HEMODIALYSIS,INITIAL THERAPY	11,368,766	77,396	146.89

Table 3 (continued)
Medicare leading procedure codes based on allowed charges by type of service with place of service inpatient:
Calendar year 1987

Procedure code	Description	Allowed charges	Allowed services	Average charge
Surgery				
ALL		$3,136,288,125	3,779,976	
52601	PROSTATECTOMY (TUR)	277,526,822	244,311	$1,135.96
27130	TOTAL HIP JOINT REPLACEMENT	147,589,633	60,003	2,459.70
27447	TOTAL KNEE REPLACEMENT	147,030,091	63,466	2,316.67
33512	CORONARY ARTERY BYPASS, 3 GRAFTS	146,271,977	37,627	3,887.42
33513	CORONARY ARTERY BYPASS, 4 GRAFTS	130,353,410	32,129	4,057.19
27244	REPAIR OF FEMUR FRACTURE	106,808,947	88,501	1,206.87
66984	REMOVE CATARACT, INSERT LENS	92,634,927	55,841	1,658.91
35301	RECHANNELING OF ARTERY	87,153,819	56,095	1,553.68
43235	UPPER GI ENDOSCOPY,DIAGNOSIS	85,688,952	280,023	306.01
93547	HEART CATHETER & ANGIOGRAM	83,059,752	118,691	699.80
44140	PARTIAL REMOVAL OF COLON	82,190,918	68,829	1,194.13
93549	HEART CATHETER & ANGIOGRAM	72,184,417	78,008	925.35
27236	REPAIR OF FEMUR FRACTURE	71,919,466	57,908	1,241.96
47605	REMOVAL OF GALLBLADDER	65,484,914	73,453	891.52
33511	CORONARY ARTERY BYPASS, 2 GRAFTS	62,262,256	17,762	3,505.36
33514	CORONARY ARTERY BYPASS, 5 GRAFTS	53,435,322	12,539	4,261.53
92982	CORONARY ARTERY DILATION	51,631,399	34,486	1,497.17
45378	DIAGNOSTIC COLONOSCOPY	51,584,259	122,238	422.00
43239	UPPER GI ENDOSCOPY, BIOPSY	50,007,118	142,429	351.10
19240	EXTENSIVE BREAST SURGERY	47,889,659	48,167	994.24
33207	INSERTION OF HEART PACEMAKER	45,972,669	43,269	1,062.49
49505	REPAIR INGUINAL HERNIA	41,815,613	79,097	528.66
35081	REPAIR DEFECT OF ARTERY	37,825,857	17,374	2,177.15
47600	REMOVAL OF GALLBLADDER	37,718,002	49,939	755.28
93503	RIGHT HEART CATHETERIZATION	37,329,634	126,304	295.55
45385	COLONOSCOPY, LESION REMOVAL	33,684,031	52,506	641.53
47610	REMOVAL OF GALLBLADDER	30,179,156	29,748	1,014.49
58150	TOTAL HYSTERECTOMY	29,776,062	31,125	956.66
33405	REPLACEMENT OF AORTIC VALVE	29,141,673	10,795	2,699.55

Table 3 (continued)
Medicare leading procedure codes based on allowed charges by type of service with place of service inpatient:
Calendar year 1987

Procedure code	Description	Allowed charges	Allowed services	Average charge
36830	ARTERY-VEIN GRAFT	27,528,732	25,408	1,083.47
27125	REVISE HIP WITH PROSTHESIS	24,739,210	16,867	1,466.72
31622	BRONCHOSCOPY, DX	24,267,917	82,657	293.60
33210	INSERTION OF HEART ELECTRODE	24,113,286	70,686	341.13
32480	PARTIAL REMOVAL OF LUNG	23,949,319	14,782	1,620.17
35656	ARTERY BYPASS GRAFT	23,749,768	14,611	1,625.47
45380	COLONOSCOPY AND BIOPSY	23,594,860	50,564	466.63
35556	ARTERY BYPASS GRAFT	23,308,569	13,835	1,684.75
44120	REMOVAL OF SMALL INTESTINE	23,195,608	24,190	958.89
44145	PARTIAL REMOVAL OF COLON	22,464,365	15,458	1,453.25
33208	INSERTION OF HEART PACEMAKER	21,745,021	15,898	1,367.78
36489	INSERTION OF CATHETER, VEIN	21,665,973	214,902	100.82
27132	CONVERT PREV. HIP SURGERY	21,125,023	8,111	2,604.49
67036	REMOVAL OF INNER EYE FLUID	20,892,080	9,694	2,155.16
67107	REPAIR DETACHED RETINA	20,537,482	12,446	1,650.13
44143	PARTIAL REMOVAL OF COLON	19,177,629	14,743	1,300.80
44005	FREEING OF BOWEL ADHESION	19,163,511	25,675	746.39
31625	BRONCHOSCOPY WITH BIOPSY	18,952,769	57,096	331.95
27590	AMPUTATE LEG AT THIGH	18,751,115	23,219	807.58
27134	REVISION OF TOTAL HIP ARTHROPLASTY	18,556,052	6,528	2,842.53
33510	CABG, 1 GRAFT	18,036,576	7,189	2,508.91
33430	REPLACEMENT OF MITRAL VALVE	17,527,988	6,288	2,787.53
49000	EXPLORATION OF ABDOMEN	17,505,707	28,521	613.78
49560	REPAIR ABDOMINAL HERNIA	17,116,492	27,920	613.05
33516	CABG, 6+ GRAFTS	16,435,113	3,657	4,494.15
45330	SIGMOIDOSCOPY	15,862,610	118,054	134.37
52240	CYSTOSCOPY AND TREATMENT	15,586,441	17,858	872.80
63030	LOW BACK DISK SURGERY	15,530,144	11,684	1,329.18
63017	RELIEVE SPINAL CORD PRESSURE	15,346,054	7,944	1,931.78
27880	AMPUTATION OF LOWER LEG	15,335,163	20,628	743.41
33206	INSERTION OF HEART PACEMAKER	15,232,248	14,895	1,022.64
58265	HYSTERECTOMY & VAGINA REPAIR	14,946,405	14,771	1,011.87
36620	ESTABLISH ACCESS TO ARTERY	14,390,017	180,263	79.83
43830	SURGICAL OPENING OF STOMACH	14,297,756	25,298	565.17
35102	REPAIR DEFECT OF ARTERY	14,290,938	6,327	2,258.72
34201	REMOVAL OF ARTERY CLOT	14,190,065	18,218	778.90

Table 3 (continued)
Medicare leading procedure codes based on allowed charges by type of service with place of service inpatient:
Calendar year 1987

Procedure code	Description	Allowed charges	Allowed services	Average charge
66983	REMOVE CATARACT, INSERT LENS	14,051,888	8,503	1,652.58
63005	RELIEVE SPINAL CORD PRESSURE	13,001,427	8,420	1,544.11
52000	CYSTOSCOPY	12,299,452	107,448	114.47
35082	REPAIR ARTERY RUPTURE, AORTA	12,076,233	4,715	2,561.24
43260	ENDOSCOPY,BILE DUCT/PANCREAS	12,039,289	25,609	470.12
35566	ARTERY BYPASS GRAFT	12,038,484	6,288	1,914.52
63042	LOW BACK DISK SURGERY	11,732,272	6,361	1,844.41
35646	ARTERY BYPASS GRAFT	11,705,717	5,876	1,992.12
27235	REPAIR OF FEMUR FRACTURE	11,657,320	9,692	1,202.78
52235	CYSTOSCOPY AND TREATMENT	11,366,333	17,321	656.22
31500	INSERTION OF WINDPIPE AIRWAY	11,235,661	126,470	88.84
50590	FRAGMENTING OF KIDNEY STONE	10,867,171	11,357	956.87
93501	RIGHT HEART CATHETERIZATION	10,746,161	26,503	405.47
50360	TRANSPLANTATION OF KIDNEY	10,640,186	5,625	1,891.59
63031	LOW BACK DISK SURGERY	10,638,056	6,361	1,672.39
44160	REMOVAL OF COLON	10,466,086	7,932	1,319.48
45110	REMOVAL OF RECTUM	10,408,356	6,556	1,587.61
31600	INCISION OF WINDPIPE	10,059,272	29,391	342.26
Consultation				
ALL		$648,172,285	9,805,782	
90620	COMPREHENSIVE CONSULTATION	333,407,954	3,645,486	$91.46
90630	COMPLEX CONSULTATION	111,020,181	923,943	120.16
90610	EXTENDED CONSULTATION	48,759,546	712,069	68.48
90642	INTERMEDIAT FOLLOWUP CONSULT	38,977,699	1,044,588	37.31
90605	INTERMEDIATE CONSULTATION	32,344,974	623,607	51.87
90643	COMPLEX FOLLOW-UP CONSULT	26,765,352	501,408	53.38
90600	LIMITED CONSULTATION	20,218,423	449,392	44.99
90641	LIMITED FOLLOW-UP CONSULT	15,645,479	560,056	27.94
80500	LAB PATHOLOGY CONSULTATION	10,893,713	470,498	23.15
93010	ECG REPORT ONLY	10,138,964	874,735	11.59

Table 3 (continued)
Medicare leading procedure codes based on allowed charges by type of service with place of service inpatient:
Calendar year 1987

Procedure code	Description	Allowed charges	Allowed services	Average charge
Diagnostic xray				
ALL		$448,039,101	19,201,272	
71010	X-RAY EXAM OF CHEST	104,347,559	8,887,351	$11.74
71020	X-RAY EXAM OF CHEST	91,173,185	6,145,803	14.84
70450	CAT SCAN OF HEAD OR BRAIN	58,185,111	647,717	89.83
70470	CONTRAST CAT SCANS OF HEAD	45,438,439	404,925	112.21
74160	CONTRAST CAT SCAN OF ABDOMEN	28,157,898	258,663	108.86
78306	NUCLEAR SCAN OF SKELETON	17,530,266	258,608	67.79
74170	CONTRAST CAT SCANS, ABDOMEN	15,642,101	129,037	121.22
74150	CAT SCAN OF ABDOMEN	14,203,693	142,334	99.79
75631	X-RAY AORTA, LEG ARTERIES	14,053,951	41,034	342.50
74000	X-RAY EXAM OF ABDOMEN	13,309,252	1,098,219	12.12
70460	CONTRAST CAT SCAN OF HEAD	13,012,621	133,477	97.49
74020	X-RAY EXAM OF ABDOMEN	11,355,392	606,491	18.72
74270	CONTRAST X-RAY EXAM OF COLON	11,201,411	352,118	31.81
71260	CONTRAST CAT SCAN OF CHEST	10,428,222	95,495	109.20
Diagnostic lab				
ALL		$267,839,338	10,738,978	
93010	ECG REPORT ONLY	102,820,694	8,092,737	$12.71
88305	SURGICAL PATHOLOGY, COMPLETE	42,729,634	745,905	57.29
88304	SURGICAL PATHOLOGY, COMPLETE	27,233,465	746,280	36.49
88307	SURGICAL PATHOLOGY, COMPLETE	24,395,303	307,803	79.26
88309	SURGICAL PATHOLOGY, COMPLETE	21,947,037	199,672	109.92
93309	ECHO EXAM OF HEART	19,891,114	190,699	104.31
76700	ECHO EXAM OF ABDOMEN	16,634,053	299,897	55.47
93307	ECHO EXAM OF HEART	12,188,038	155,985	78.14

Table 3 (continued)
Medicare leading procedure codes based on allowed charges by type of service with place of service inpatient:
Calendar year 1987

Procedure code	Description	Allowed charges	Allowed services	Average charge
Anesthesia				
ALL		$274,930,346	1,080,313	
52601	PROSTATECTOMY (TUR)	43,686,993	233,867	$186.80
33512	CORONARY ARTERY BYPASS, 3 GRAFTS	28,133,182	49,714	565.90
27130	TOTAL HIP JOINT REPLACEMENT	21,916,779	71,141	308.08
33513	CORONARY ARTERY BYPASS, 4 GRAFTS	18,860,437	35,818	526.56
44140	PARTIAL REMOVAL OF COLON	18,492,908	72,467	255.19
27236	REPAIR OF FEMUR FRACTURE	17,429,100	72,711	239.70
35301	RECHANNELING OF ARTERY	16,883,933	54,559	309.46
27447	TOTAL KNEE REPLACEMENT	14,565,109	52,692	276.42
49000	EXPLORATION OF ABDOMEN	13,746,610	58,995	233.01
47600	REMOVAL OF GALLBLADDER	13,503,112	60,243	224.14
47605	REMOVAL OF GALLBLADDER	13,028,052	57,940	224.85
49505	REPAIR INGUINAL HERNIA	11,931,922	71,910	165.93
66984	REMOVE CATARACT, INSERT LENS	11,132,164	61,301	181.60
33511	CORONARY ARTERY BYPASS, 2 GRAFTS	10,823,041	20,810	520.09
66983	REMOVE CATARACT, INSERT LENS	10,571,871	58,594	180.43
27244	REPAIR OF FEMUR FRACTURE	10,225,133	47,551	215.04
Assistant at surgery				
ALL		$66,978,983	105,016	
33512	CORONARY ARTERY BYPASS, 3 GRAFTS	20,260,804	24,445	$828.83
33513	CORONARY ARTERY BYPASS, 4 GRAFTS	17,729,602	20,477	865.83
27130	TOTAL HIP JOINT REPLACEMENT	14,975,495	29,882	501.15
27447	TOTAL KNEE REPLACEMENT	14,013,082	30,212	463.83

SOURCE: HCFA, BDMS, BMAD System, Procedure File.

Table 4
Medicare leading procedure codes based on allowed charges by type of service with place of service outpatient:
Calendar year 1987

Procedure code	Description	Allowed charges	Allowed services	Average charge
Medical care				
ALL		$287,298,797	7,665,326	
90515	EMERGENCY CARE, NEW,INTERMEDIATE	77,161,055	2,136,123	$36.12
90517	EMERGENCY CARE, NEW, EXTENDED	69,587,423	1,393,813	49.93
90510	EMERGENCY CARE, NEW, LIMITED	38,888,167	1,553,257	25.04
M0945	OUTPATIENT DIALYSIS RELATED PHYSICIAN	34,282,535	656,411	52.23
90520	EMERGENCY DEPT., COMPHR, EST PATIENT	27,106,101	501,499	54.05
90560	EMERGENCY CARE, INTERMEDIATE	14,318,322	624,755	22.92
99160	CRITICAL CARE, EACH HOUR	13,701,591	157,243	87.14
90505	EMERGENCY CARE, NEW, BRIEF	12,253,603	642,225	19.08
Surgery				
ALL		$1,932,150,131	2,092,690	
66984	REMOVE CATARACT, INSERT LENS	1,303,151,224	778,747	$1,673.39
66983	REMOVE CATARACT, INSERT LENS	90,486,852	55,578	1,628.11
45385	COLONOSCOPY, LESION REMOVAL	72,373,476	114,522	631.96
66821	LASERING, SECONDARY CATARACT	66,920,521	136,309	490.95
45378	DIAGNOSTIC COLONOSCOPY	65,175,303	156,483	416.50
43235	UPPER GI ENDOSCOPY,DIAGNOSIS	44,270,684	150,379	294.39
43239	UPPER GI ENDOSCOPY, BIOPSY	36,927,916	109,050	338.63
65855	LASER SURGERY OF EYE	34,120,696	43,355	787.01
66985	INSERT LENS PROSTHESIS	32,782,074	30,919	1,060.26
67228	TREATMENT OF RETINAL LESION	31,597,133	43,030	734.30
45380	COLONOSCOPY AND BIOPSY	28,935,647	62,719	461.35
19120	REMOVAL OF BREAST LESION	15,389,827	55,740	276.10
64721	REVISE MEDIAN NERVE AT WRIST	15,309,130	31,971	478.84
29881	KNEE ARTHROSCOPY/SURGERY	14,784,637	14,332	1,031.58
52000	CYSTOSCOPY	14,543,300	122,793	118.44
45330	SIGMOIDOSCOPY	14,267,345	108,440	131.57

Table 4 (continued)
Medicare leading procedure codes based on allowed charges by type of service with place of service outpatient:
Calendar year 1987

Procedure code	Description	Allowed charges	Allowed services	Average charge
49505	REPAIR INGUINAL HERNIA	14,086,320	25,319	556.35
66170	INCISION OF EYE	13,525,155	17,386	777.93
66761	REVISION OF IRIS	12,532,132	20,198	620.46
67210	TREATMENT OF RETINAL LESION	10,970,759	15,420	711.46
Consultation				
ALL		$10,309,027	146,380	
90620	COMPREHENSIVE CONSULTATION	10,309,027	146,380	$70.43
Diagnostic xray				
ALL		$214,924,027	7,764,325	
71020	X-RAY EXAM OF CHEST	58,796,211	3,961,189	$14.84
70470	CONTRAST CAT SCANS OF HEAD	28,713,221	257,976	111.30
76091	X-RAY EXAM OF BREASTS	23,355,546	814,367	28.68
74160	CONTRAST CAT SCAN OF ABDOMEN	22,241,417	206,741	107.58
78306	NUCLEAR SCAN OF SKELETON	20,247,636	298,437	67.85
70450	CAT SCAN OF HEAD OR BRAIN	17,936,825	203,676	88.07
71010	X-RAY EXAM OF CHEST	17,563,046	1,517,766	11.57
74170	CONTRAST CAT SCANS, ABDOMEN	13,920,322	115,203	120.83
74270	CONTRAST X-RAY EXAM OF COLON	12,149,803	388,970	31.24
Diagnostic lab				
ALL		$67,386,999	2,702,874	
88305	SURGICAL PATHOLOGY, COMPLETE	26,078,153	468,059	$55.72
93010	ECG REPORT ONLY	21,126,950	1,649,417	12.81
88304	SURGICAL PATHOLOGY, COMPLETE	20,181,896	585,398	34.48

Table 4 (continued)
Medicare leading procedure codes based on allowed charges by type of service with place of service outpatient:
Calendar year 1987

Procedure code	Description	Allowed charges	Allowed services	Average charge
Radiation therapy				
ALL		$85,488,710	2,302,004	
77410	DAILY RADIATION THERAPY	38,178,133	847,085	$45.07
77405	DAILY RADIATION THERAPY	31,883,900	881,535	36.17
77400	DAILY RADIATION THERAPY	15,426,677	573,384	26.90
Anesthesia				
ALL		$101,073,031	625,524	
66984	REMOVE CATARACT, INSERT LENS	61,504,367	395,957	$155.33
66983	REMOVE CATARACT, INSERT LENS	39,568,664	229,567	172.36
Assistant at surgery				
ALL		$11,625,435	32,252	
66984	REMOVE CATARACT, INSERT LENS	11,625,435	32,252	$360.46
Other medical service				
ALL		$200,210,979	1,039,567	
V2632	POSTERIOR CHAMBER IOL	39,302,192	117,301	$335.05
A0010	AMBULANCE SERVICE, BASIC LIFE SUPPORT	37,173,690	358,275	103.76
M0053	ASC FACILITY CHARGE	37,086,502	110,077	336.91
66984	REMOVE CATARACT, INSERT LENS	36,009,304	70,770	508.82
M0054	MISC ASC CHARGES	25,065,442	43,757	572.83
M0050	ASC CHARGE GROUP I	14,269,477	58,603	243.49
A0020	AMBULANCE SERVICE, (BLS) LIFE SUPPORT	11,304,372	280,784	40.26

SOURCE: HCFA, BDMS, BMAD System, Procedure File.

Table 5
Medicare leading procedure codes based on allowed charges by type of service, with place of service independent lab: Calendar year 1987

Procedure code	Description	Allowed charges	Allowed services	Average charge
Diagnostic lab				
ALL		$413,388,124	35,146,615	
80019	AUTOMATED MULTICHANNEL TEST	122,865,685	7,047,961	$17.43
85022	BLOOD COUNT, HEMOGRAM	30,054,263	3,322,376	9.05
82643	DIGOXIN, RIA	29,202,026	1,377,997	21.19
85025	BLOOD: HEMOGRAM/PLATELET-AUTO DIFF WBC	27,687,528	2,376,670	11.65
84436	THYROXINE TRUE (TT-4, RIA)	24,923,382	2,519,534	9.89
83718	LIPOPROTEIN DEN CHOLESTEROL BY PRECIP	24,415,073	2,020,837	12.08
88304	SURGICAL PATHOLOGY, COMPLETE	23,923,527	698,467	34.25
84443	THYROID STIMULATING HORMONE TEST	23,657,327	894,856	26.44
82947	GLUCOSE, EXCEPT URINE	16,147,369	2,509,792	6.43
81000	URINALYSIS, WITH MICRSCOPY	15,515,429	2,851,569	5.44
85610	PROTHROMBIN	15,206,368	2,238,792	6.79
88305	SURGICAL PATHOLOGY, COMPLETE	12,942,776	249,715	51.83
87086	CULTURE, BACTERIAL, URINE	12,846,188	1,035,156	12.41
36415	COLLECTION OF VENOUS BLOOD	12,462,559	4,139,939	3.01
82756	FREE THROXINE (T-7)	11,051,678	716,926	15.42
84479	TRIIODOTHYRONINE (T-3), RESIN UPTAKE	10,486,946	1,146,028	9.15

SOURCE: HCFA, BDMS, BMAD System, Procedure File.

Table 6
Medicare leading procedure codes based on allowed charges by type of service with place of service other:
Calendar year 1987

Procedure code	Description	Allowed charges	Allowed services	Average charge
Medical care				
ALL		$252,634,984	8,777,315	
90360	CARE FACILITY VISIT,INTERMEDIATE	47,473,407	1,793,460	$26.47
90350	CARE FACILITY VISIT, LIMITED	39,335,927	1,693,646	23.23
90450	CARE FACILITY VISIT, LIMITED	27,191,200	1,282,861	21.20
90460	CARE FACILITY VISIT,INTERMEDIATE	25,962,491	1,002,517	25.90
M0945	OUTPATIENT DIALYSIS RELATED PHYSICIAN	24,146,344	426,316	56.64
90160	HOME VISIT, INTERMEDIATE	20,561,617	584,541	35.18
90340	CARE FACILITY VISIT, BRIEF	14,914,890	764,631	19.51
90150	HOME VISIT, LIMITED	14,645,105	471,367	31.07
90320	CARE FACILITY VISIT, COMPREHENSIVE	13,974,464	238,571	58.58
90370	CARE FACILITY VISIT, EXTENDED	13,570,220	409,259	33.16
90991	HOME HEMODIALYSIS CARE	10,859,319	110,146	98.59
Diagnostic xray				
ALL		$32,213,097	684,802	
R0070	PORTABLE X-RAY TRANSPORTATION	19,755,523	317,698	$62.18
71010	X-RAY EXAM OF CHEST	12,457,574	367,104	33.93

Table 6 (continued)
Medicare leading procedure codes based on allowed charges
by type of service with place of service other:
Calendar year 1987

Procedure code	Description	Allowed charges
Other medical service		
ALL		$1,811,318,340
E1396	OXYGEN CONCENTRATOR, EQUIV. TO OVER 1952	256,971,840
A0010	AMBULANCE SERVICE, BASIC LIFE SUPPORT	229,122,483
E0410	OXYGEN CONTENTS, LIQUID, PER POUND	151,579,611
A0220	AMBULANCE SERV., ADVANCED LIFE SUPPORT	71,709,266
A0020	AMBULANCE SERVICE, (BLS) LIFE SUPPORT	71,309,795
B4150	ENTERAL FORMULAE; CATEGORY I	62,700,874
B4035	ENTERAL FEEDING SUPPLY KIT;-PUMP MONTHLY	62,144,605
E0620	SEAT LIFT CHAIR, MOTORIZED	59,716,057
E0260	HOSPITAL BED, W/SIDE RAILS SEMI ELECTRIC	54,634,601
E0265	HOSPITAL BED, TOTAL ELECTRIC W/SIDE RAILS	54,504,786
E0255	HOSPITAL BED, W/SIDE RAILS VARIABLE HEIGHT	45,956,385
E0435	OXYGEN SYS-LIQUID, PORTABLE	45,415,558
A4900	CONTINOUS AMBULATORY PERITONEAL DIALYSIS	41,629,034
E0730	TENS FOUR LEAD, NERVE STIMULATION	34,250,178
E1130	STD WHEELCHAIR	33,954,364
E0430	PORTABLE GASEOUS OXYGEN SYSTEM	30,926,658
E0570	NEUTRALIZER WITH COMPRESSOR	26,242,074
B4189	PARENTERAL NUTRITION SOLUTION, PREMIXED	25,467,024
A0222	AMBULANCE SERV., RETURN TRIP	25,380,715
E0250	HOSPITAL BED	25,127,088
E1150	WHEELCHAIR, SWING/DETACH/ELEVATE LEG RES	23,116,021
V2632	POSTERIOR CHAMBER IOL	20,625,945
E0163	COMMODE CHAIR	20,052,905
A0150	NON-EMERG AMBULANCE, ONE-WAY	19,379,542
A0223	AMBULANCE SERV., ADVAN LIFE SUPPORT, ONE	19,167,903
L5100	BELOW KNEE, MOLDED SOCKET, SHIN	18,925,098
E1394	OXYGEN CONCENTRATOR, EQUIV TO OVER 1708	18,508,645

Table 6 (continued)
Medicare leading procedure codes based on allowed charges by t
with place of service other:
Calendar year 1987

Procedure code	Description	Allowed charges
E1140	WHEELCHAIR, DETACH ARMS	16,583,648
E0440	OXYGEN SYSTEM, LIQUID STATIONARY	16,349,660
V2020	FRAMES PURCHASE	15,211,754
E1160	WHEELCHAIR-FIXED ARMS/SWING/DETACH/LEG REST	14,576,287
A0070	AMBULANCE SERVICE W/ OXYGEN & LIFE SUPPORT	13,914,224
E1400	OXYGEN CONCENTRATOR	13,391,827
E1230	WHEELCHAIR, POWER OPERATED	13,261,553
A4421	MISC OSTOMY SUPPLIES	13,174,026
B9002	ENTERAL NUTRITION INFUSION PUMP W/ALARM	12,433,387
A4348	URINARY COLLECTION AND RETENTION	12,343,645
E0630	PATIENT LIFT HYDRAULIC	12,152,505
E0135	WALKER FOLDING (PICK-UP)	12,136,266
E1395	OXYGEN CONCENTRATOR, EQUIV. TO 1952 CU.	11,766,367
A4366	OSTOMY BAG, REUSABLE OR DRAINABLE	11,765,680
E0425	STATIONARY COMPRESSED GAS SYS	11,007,614
E1399	DME NOT OTHERWISE CLASSIFIED	10,759,537
B4036	EXTERNAL FEEDING SUPPLY KIT-GRAVITY FEED	10,607,398
V2203	SPHEREOCYLINDER FIFOCAL	10,605,563
A4350	CATHETER CARE KIT	10,439,989
A4365	OSTOMY BAG, DISPOSABLE/CLOSED	10,188,772
E0400	OXYGEN CONTENTS, GASEOUS PER 100 CU FT	10,129,583

SOURCE: HCFA, BDMS, BMAD System, Procedure File.

Section VI

Charges and Payments by Physician Specialty

- Internal medicine specialists accounted for the largest share of all allowed charges for physician/supplier services in 1987, 14.6 percent or $4.4 billion, followed by ophthalmologists, 10.5 percent or $3.2 billion, and radiologists, 7.5 percent or $2.2 billion (Table 1, Figure 1). Internal medicine has also consistently represented the largest share of program payments, although that share is decreasing. (Table 4, Figure 1). Total payment to this group in 1987 was nearly twice what it was in 1981 (Figure 2).

- Physician Participation Program rates by allowed charges vary widely by physician specialty (Table 2). While about half of all physician allowed charges are submitted by participating physicians, 70 percent of all nephrologists' charges, but only 29 percent of anesthesiologists' charges, were submitted under the Physician Participation Program in 1987.

- On any given bill, non-participating physicians may submit "assigned" charges, i.e., they accept Medicare's determination on reasonable charges and thus do not bill patients for charges exceeding these allowed charges, or they may submit "unassigned" charges, i.e., they do not accept Medicare's determination on reasonable charges and thus may bill patients for charges exceeding these allowed charges. About 43 percent of all anesthesiologists' allowed charges were unassigned in 1987 compared to 27 percent for all physicians and only 7 percent for nephrologists (Table 2). Unassigned charges in excess of reasonable charges are often termed "balance billings".

- About 8 percent of total liabilities (allowed charges plus balance billings) for physician services were balance billings in 1987 (Table 2). Balance billings as a percent of total liabilities were highest for anesthesiologists, 22 percent, and for most surgical specialties.

- Program payments as a percent of allowed charges vary by physician specialty because primary care physicians are more likely to submit charges subject to the SMI deductible than other physicians and because

some physicians provide more care under established fees not subject to the Part B coinsurance. About 76 percent of allowed charges for all physicians are reimbursed under the program compared to about 69 percent for general family practice and dermatologists (Table 2). Almost no anesthesiologists' allowed charges are subject to the SMI deductible since about 80 percent of their allowed charges are reimbursed (the remaining 20 percent represents coinsurance). Since ophthalmologists are frequently paid established fees not subject to the SMI coinsurance or deductible, they are reimbursed about 83 percent of their submitted charges.

- Currently, HCFA cannot associate billings with individual physicians but can associate them with billing arrangements. Arrangements represent customary charge profiles in different pricing localities. Thus a physician who has a practice in more than one pricing locality may be represented by more than one arrangement. For example, a physician may bill for a private practice under one arrangement, for a group practice under another arrangement or for a hospital based practice under yet another arrangement. Under a Congressional mandate, HCFA is currently developing a unique provider identification number (UPIN) program so that Medicare payments for all arrangements can be attributed to individual physicians.

- In 1987, the 610 thousand physician arrangements that bill Medicare incurred average Medicare allowed charges per arrangement of about $43,000 (Table 3). Average allowed charges per arrangement ranged from $124,000 for thoracic surgery specialties to less than $20,000 for podiatrists. The maximum amount of allowed charges for any single arrangement observed in a 5 percent sample of all arrangements processed in HCFA's central record system was $5.1 million (for a radiologist arrangement). One ophthalmologist arrangement had $5.0 million in allowed charges in 1987. These data should be interpreted cautiously since some physicians or physician groups may be primary billing agents for other assisting physicians (and thus the maximum charge overstates that physician's Medicare billing share) and since some physicians may have other billing arrangements (and thus the maximum charge understates that physician's Medicare billing share).

- Medicare program payments for non-physician services comprise a growing percentage of all payments for physician/supplier services (Table 4). In 1981, over 90 percent of such payments were paid to physicians

compared to 86 percent in 1987. While the top ten physician specialties ranked by total payment changed very little from 1981 to 1987, the order of the ten did (Table 4, Figure 2). While overall payments to physicians/suppliers increased nearly 26 percent from 1986 to 1987, payments to optometrists rose 114 percent (Table 4, Figure 3).

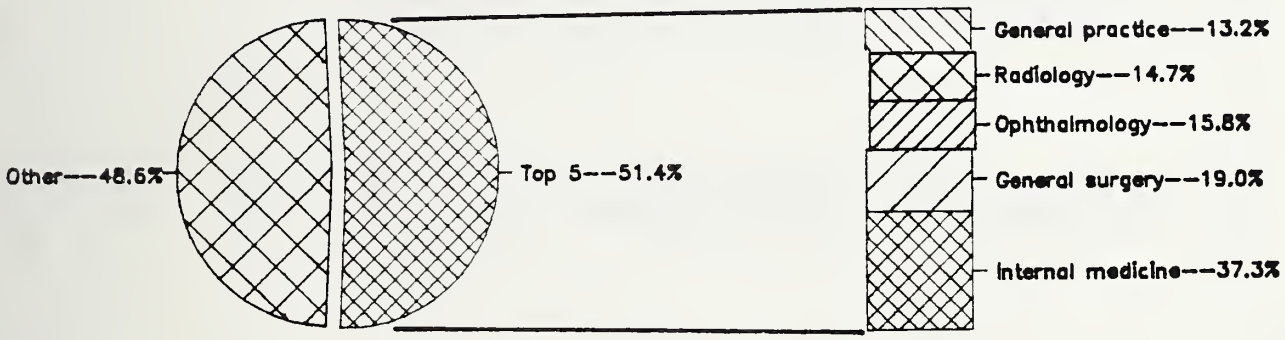
Table 1
Estimated Medicare dollar amount and percent distribution of allowed charges for physician and other non-institutional suppliers: Calendar year 1987

	Amount	Percent
	Dollars in millions	
Total	$30,050	100.00
Medical Doctors and Osteopaths	26,032	86.63
General/Family Practice	2,185	7.27
Medical Specialties	7,804	25.97
Internal Medicine	4,399	14.64
Cardiovascular Disease	1,719	5.72
Gastroenterology	565	1.88
Dermatology	433	1.44
Pulmonary Disease	346	1.15
Nephrology	279	0.93
Other	63	0.21
Surgical Specialties	8,997	29.94
Ophthalmology	3,158	10.51
General Surgery	1,902	6.33
Orthopedic Surgery	1,319	4.39
Urology	923	3.07
Thoracic Surgery	829	2.76
Eye, Ear, Nose and Throat	276	0.92
Neurological Surgery	213	0.71
Obstetrics/Gynecology	183	0.61
Plastic Surgery	129	0.43
Other	63	0.21
Other Specialties	5,376	17.89
Radiology	2,248	7.48
Anesthesiology	1,136	3.78
Neurology	340	1.13
Psychiatry	334	1.11
Pathology	297	0.99
Physical Medicine and Rehabilitation	105	0.35
Other Physician and Unknown Physician	460	1.53
Clinic	1,584	5.27
Osteopaths 1/	87	0.29
Non-Physician Professionals and Suppliers	4,018	13.37
Podiatry	457	1.52
Chiropractor	141	0.47
Optometrist	105	0.35
Other Professional	144	0.48
Independent Laboratories	905	3.01
Ambulance	625	2.08
Other Suppliers	2,097	6.98

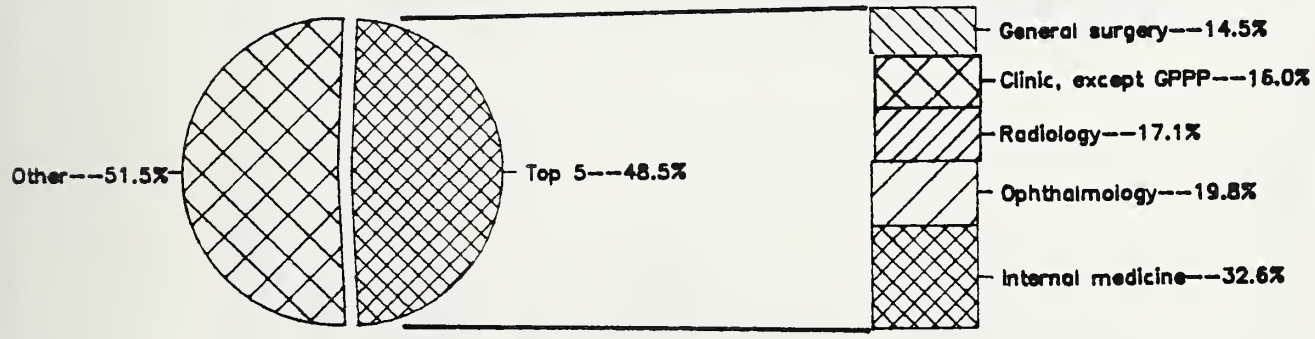
1/ Represents only a portion of osteopaths. Most are reported in other physician specialties.

SOURCE: HCFA, BDMS, BMAD System, Procedure File.

Figure 1
Medicare relative payments for top 5 specialties (physician specialties only), Calendar years 1981 and 1987



1981 Top 5 specialties



1987 Top 5 specialties

Prepared by Division of Information Analysis

Table 2
Medicare percentage distribution of charges and payments by physician speciality:
Calendar year 1987

Physician Specialty	Total	Allowed charges			Balance billing as a percent of total liability by specialty	Reimbursement as a percent of allowed charges
		Participating Physicians	Non-participating physicians			
			Assigned	Unassigned		
General/Family Practice	100.0	42.7	26.1	31.3	8.1	68.9
Medical Specialties	100.0	49.1	24.8	26.1	6.1	75.0
Cardiovascular Disease	100.0	54.0	22.0	24.0	5.7	76.0
Internal Medicine	100.0	44.1	26.8	29.1	6.7	74.1
Pulmonary Diseases	100.0	52.6	26.9	20.5	5.6	76.8
Nephrology	100.0	69.7	23.1	7.2	2.7	77.9
Dermatology	100.0	55.4	17.0	27.6	6.0	69.7
Gastroenterology	100.0	56.3	24.0	19.7	4.2	72.2
Surgical Specialties	100.0	49.1	23.2	27.7	8.6	78.5
General Surgery	100.0	50.0	22.4	27.7	9.2	76.9
Neurological Surgery	100.0	40.6	24.1	35.3	15.7	75.8
Obstetric/Gynecology	100.0	41.8	23.5	34.7	15.6	72.6
Ophthalmology	100.0	54.9	24.0	21.1	5.2	82.9
Orthopedic Surgery	100.0	40.1	23.1	36.7	11.9	76.0
Otolaryngology	100.0	38.7	24.1	37.2	12.1	72.2
Plastic Surgery	100.0	42.1	27.0	30.9	15.1	78.6
Thoracio Surgery	100.0	58.5	20.0	21.5	6.0	76.5
Urology	100.0	40.0	23.9	36.1	10.6	75.9
Other Specialties	100.0	51.1	21.8	27.2	10.6	76.1
Psychiatry	100.0	52.3	32.5	15.2	9.5	73.8
Physicial Medicine and Rehabilitation	100.0	73.8	17.2	9.0	3.5	77.1
Pathology	100.0	60.8	17.1	22.2	9.6	78.4
Podiatry	100.0	54.2	24.8	20.9	5.7	70.4
Anesthesiology	100.0	29.2	27.4	43.5	21.7	79.8
Neurology	100.0	46.5	29.0	24.4	7.4	76.0
Radiology	100.0	59.5	16.6	24.0	6.1	75.2
Other	100.0	64.9	15.2	19.9	6.4	76.4
Clinic	100.0	50.1	22.8	27.1	8.0	73.8
All Physicians	100.0	49.2	23.8	27.0	8.1	75.8

1/ Excludes non-billed charges applied to the SMI deductible.

SOURCE: HCFA, BDMS, BMAD System, Beneficiary File.

Table 3
Medicare physician charges, allowed charges, number of arrangements, average allowed charges per arrangement, maximum arrangement charges by selected physician specialty, calendar year 1987 and AMA physician census, as of Oecember 31, 1986

	Allowed Charges		Arrangements		Average Charges Per Arrangement	Maximum Arrangement Charges	AMA Physicians (1986)	
	Amount	Percent	Number	Percent			Number	Percent
	in millions					in thousands		
All Physician	$26,103	100.0%	609,860	100.0%	$42,801	$5,114	444,705	100.0%
General/Family Practice	2,894	11.1	135,680	22.3	21,332	678	63,506	14.3
Medical Specialties	7,538	28.9	161,060	26.4	46,803	2,627	139,957	31.5
Internal Medicine	4,065	15.6	100,500	16.5	40,452	1,215	77,920	17.5
Cardiovascular	1,766	6.8	24,100	4.0	73,260	2,627	11,799	2.7
Other	1,707	6.5	36,460	6.0	45,723	1,106	50,238	11.3
Surgical Specialties	8,637	33.1	165,120	27.1	52,310	5,044	120,705	27.1
General	1,922	7.4	40,580	6.7	47,359	1,402	34,251	7.7
Orthopedic	1,137	4.4	23,280	3.8	48,837	892	16,607	3.7
Thoracic	676	2.6	5,460	0.9	123,886	1,673	1,887	0.4
Urology	832	3.2	13,480	2.2	61,716	1,232	8,420	1.9
Ophthalmology	3,233	12.4	27,360	4.5	118,161	5,044	14,237	3.2
Other	837	3.1	54,960	9.0	15,238	702	45,303	10.2
Other Specialties	5,053	19.4	133,520	21.9	37,846	5,114	120,537	27.1
Anesthesiology	1,108	4.3	25,940	4.3	42,727	1,963	21,440	4.8
Podiatry	670	1.8	24,060	4.0	19,533	543	N/S	N/S
Radiology	2,090	8.0	23,380	3.8	89,360	5,114	19,888	4.5
Other and Unknown	1,185	5.3	60,140	9.9	23,028	2,091	---	---
Clinic	1,980	7.6	14,480	2.4	136,722	13,320	N/S	N/S

SOURCE: HCFA, BOMS, BMAD System, Provider File and AMA Specialty Profiles.

Table 4
Medicare payments to physicians and Part B suppliers, ranked by 1987 payments: Selected calendar years

	1987				1984			1981	
	Amount	Percent change from 1986	Percent of Total	Annualized percentage change 1981-1987	Amount	Percent change from 1983	Percent of Total	Amount	Percent of Total
Total physician and Part B suppliers	$20,432,576	25.7%	100.0%	13.9%	$13,288,923	13.4%	100.0%	$9,375,720	100.0%
Total physician specialties	17,612,264	25.5	86.2	13.0	11,749,543	12.4	88.4	8,476,159	90.4
Internal medicine	2,783,901	26.1	13.6	9.4	2,003,513	6.4	15.1	1,627,554	17.4
Ophthalmology	1,693,834	16.4	8.3	16.2	1,242,630	21.5	9.4	688,669	7.3
Radiology	1,459,180	24.4	7.1	14.7	912,470	17.8	6.9	639,746	6.8
Clinic, except GPPP	1,368,340	39.4	6.7	17.2	795,798	12.9	6.0	527,115	5.6
General surgery	1,236,695	18.8	6.1	6.9	984,413	7.7	7.4	826,539	8.8
ASC and other	1,105,610	44.8	5.4	73.3	195,028	140.2	1.5	40,847	0.4
Cardiovascular disease	1,088,460	32.6	5.3	19.6	613,657	18.6	4.6	371,666	4.0
Orthopedic surgery	851,254	20.1	4.2	10.2	633,080	12.1	4.8	475,689	5.1
Anesthesiology	715,802	15.3	3.5	10.1	558,873	15.4	4.2	401,219	4.3
Family practice	663,787	25.1	3.2	13.2	435,031	11.3	3.3	316,001	3.4
General practice	652,227	12.3	3.2	2.1	595,054	0.0	4.5	575,547	6.1
Urology	609,488	22.9	3.0	8.3	448,791	9.0	3.4	377,163	4.0
Thoracic surgery	568,337	24.7	2.8	11.8	395,138	11.8	3.0	291,077	3.1
Gastroenterology	338,604	30.8	1.7	20.4	187,151	18.8	1.4	111,414	1.2
Podiatry/surgical chiropody	273,721	30.4	1.3	10.9	186,318	6.1	1.4	146,972	1.6
Dermatology	259,522	29.8	1.3	16.3	147,631	14.5	1.1	105,066	1.1
Pulmonary diseases	221,426	29.1	1.1	19.9	128,040	15.8	1.0	74,587	0.8
Neurology	217,608	28.6	1.1	14.0	146,721	12.4	1.1	98,895	1.1
Psychiatry	208,229	26.8	1.0	23.2	141,003	7.8	1.1	59,413	0.6
Pathology	204,795	29.1	1.0	8.3	112,866	-6.6	0.8	127,056	1.4
Nephrology	174,308	91.6	0.9	13.2	112,913	5.8	0.8	82,926	0.9
Oto, laryngo, rhino	164,952	20.8	0.8	10.0	119,717	11.5	0.9	93,044	1.0
Neurological surgery	151,797	15.3	0.7	8.9	119,719	9.3	0.9	90,906	1.0
Ob-gynecology	115,290	26.6	0.6	10.0	76,950	9.5	0.6	64,934	0.7
Chiropractor, licensed	82,801	20.4	0.4	6.3	71,449	9.5	0.5	57,533	0.6
Plastic surgery	78,568	22.1	0.4	12.3	53,711	12.6	0.4	39,074	0.4
Physical medicine/rehab	66,866	42.2	0.3	19.7	38,899	20.9	0.3	22,680	0.2
Optometry	55,699	113.9	0.3	113.9	na			na	
Unknown specialty	48,387	-43.0	0.2	3.2		-100.0	0.0	39,960	0.4
Proctology	35,901	15.0	0.2	11.5	24,205	15.6	0.2	18,685	0.2
Allergy	21,399	22.9	0.1	8.8	14,588	4.3	0.1	12,927	0.1
Nuclear medicine	15,185	24.6	0.1	9.7	11,570	21.2	0.1	8,706	0.1
Radiation therapy (DO)	13,482	50.5	0.1	36.0	4,413	37.0	0.0	2,132	0.0
Pediatrics	13,285	54.7	0.1	7.4	9,152	5.7	0.1	8,636	0.1

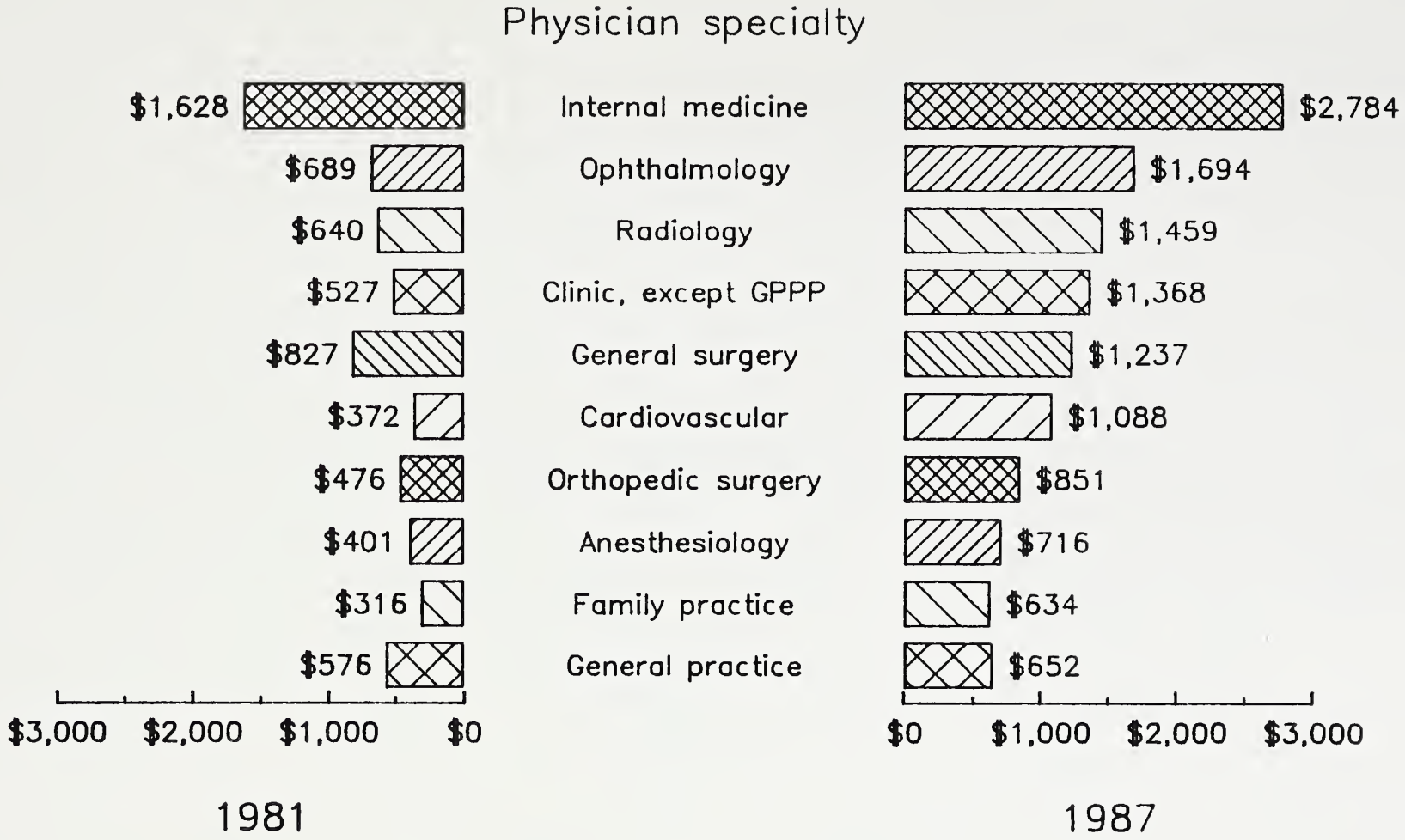
Table 4 (continued)
Medicare payments to physicians and Part B suppliers,
ranked by 1987 payments:
Selected calendar years

	1987				1984			1981	
	Amount	Percent change from 1986	Percent of Total	Annualized percentage change 1981-1987	Amount	Percent change from 1983	Percent of Total	Amount	Percent of Total
Eye, ear, nose, throat (DO)	10,128	5.5	0.0	2.1	11,081	20.6	0.1	8,928	0.1
Radiology (DO)	9,740	13.8	0.0	5.5	6,535	10.1	0.0	7,063	0.1
Oral surgery (DDS)	7,474	35.3	0.0	12.3	4,754	12.4	0.0	3,720	0.0
Manipulative therapy (DO)	6,970	-10.9	0.0	-1.5	7,864	6.5	0.1	7,609	0.1
Vascular disease (DO)	5,649	0.0	0.0	2.7	5,722	16.9	0.0	4,812	0.1
Hand surgery	4,783	30.0	0.0	25.4	2,398	33.7	0.0	1,229	0.0
Psychiatry (DO)	3,458	6.3	0.0	-3.4	4,107	0.8	0.0	4,245	0.0
Gynecology (DO)	2,164	-48.9	0.0	-16.4	8,901	15.2	0.1	6,345	0.1
Geriatrics	1,691	56.1	0.0	13.0	740	-19.6	0.0	812	0.0
Pathology (DO)	771	-12.5	0.0	-7.0	875	-35.0	0.0	1,195	0.0
Obstetrics (DO)	594	-22.3	0.0	-31.6	601	-74.1	0.0	5,823	0.1
Total suppliers	2,793,177	27.7	13.7	21.4	1,523,011	49.6	11.5	871,825	9.3
Companies and individuals with orthotic orthotic and/or prosthetic certification certification									
Medical supply w/ c.o.	8,831	1.6	0.0	13.7	10,295	46.8	0.1	4,095	0.0
Medical supply w/ c.p.	12,795	7.0	0.1	11.1	8,688	17.4	0.1	6,790	0.1
Medical supply w/ c.p.o.	36,271	16.1	0.2	17.9	19,793	18.0	0.1	13,503	0.1
Medical supply - other	1,017,065	30.1	5.0	18.5	615,397	21.1	4.6	367,317	3.9
Individual w/ c.o.	1,096	18.2	0.0	12.6	863	-2.7	0.0	537	0.0
Individual w/ c.p.	748	13.9	0.0	6.2	641	7.0	0.0	520	0.0
Individual w/ c.p.o.	1,508	62.5	0.0	6.3	1,027	-38.9	0.0	1,047	0.0
Individual - other	30,740	10.1	0.2	6.6	35,937	6.2	0.3	20,920	0.2
Ambulance	413,325	16.3	2.0	18.3	237,336	--	1.8	150,888	1.6
Public health	497	-56.3	0.0	-5.8	1,022	-10.4	0.0	711	0.0
Voluntary/charitable org.	1	-85.7	0.0	-10.9	6	0.0	0.0	2	0.0
Psychologist (bill. indep.)	3,281	27.1	0.0	12.3	1,691	-24.7	0.0	1,636	0.0
Portable X-ray (bill. indep.)	39,233	31.2	0.2	20.4	17,720	13.6	0.1	12,872	0.1
Audiologist (bill. indep.)	3,222	61.1	0.0	31.4	1,244	29.6	0.0	626	0.0
Physical therapist (bill. indep.)	22,978	24.3	0.1	38.4	12,573	20.5	0.1	3,270	0.0
Independent laboratory	796,296	31.0	3.9	31.9	256,190	36.7	1.9	151,456	1.6
All other suppliers	392,799	17.2	1.9	19.5	301,156	35.1	2.3	134,864	1.4
Unknown suppliers	12,477	169.8	0.1	59.0	1,423	19.3	0.0	771	0.0
				0.0		0.0			
Total GPPP	2,974	128.8	0.0	43.5 1/	340	-24.8	0.0	1/	--

1/ Amount too small to record.
2/ Annualized from 1984 to 1987.
NOTE: DO = Doctor of Osteopathy

SOURCE: HCFA, BDMS, Medicare Statistical System, Payment Records.

Figure 2
Medicare payments for top 10 physician specialties, CY 1987 ranking ($ in millions)



Prepared by Division of Information Analysis

Section VII

Trends in Physician Populations, Income, and Expenses

- The number of active physicians per 100,000 general population grew 47 percent from 1970 to 1987 (156 physicians per 100,000 persons in 1970 and 229 in 1987) (Table 1). The rate is projected to rise to 264 physicians per 100,000 persons in the year 2000.

- The ratio of non-federal patient care physicians per 100,000 general population varies widely by HCFA region, ranging from a maximum of 236 in the Boston Region to a minimum of 148 in the Dallas Region (Table 2, Figure 1.) "Patient care" physicians are a subset of "active" physicians.

- The mean net income of all physicians, after expenses and before taxes, was $132 thousand in 1987, up from $118 thousand in 1986 (Table 3). Physician mean net incomes have steadily increased in recent years.

- Mean net incomes vary widely by physician specialty (Table 4). In 1987, surgeons' mean net income, $188 thousand, was more than twice that for general/family practitioners, $92 thousand.

Table 1
Physician census trends

Year	Type of Physician: Total	Doctors of medicine (M.D.)	Doctors of osteopathy (D.O.)	Active physicians per 100,000 population
1987	557,800	533,800	24,100	229
1986	544,800	522,000	22,800	225
1985	534,800	512,900	21,900	220
1984	n/a	n/a	n/a	n/a
1983	501,200	481,500	19,700	211
1982	483,700	465,000	18,700	205
1981	466,700	448,700	18,000	199
1980	457,500	440,400	17,100	197
1979	440,400	424,000	16,400	191
1978	424,000	408,300	15,700	186
1977	405,900	390,800	15,100	180
1976	399,500	385,000	14,500	179
1975	384,500	370,400	14,100	174
1974	370,000	356,400	13,600	169
1973	355,700	342,500	13,200	164
1972	348,300	335,500	12,800	163
1971	337,400	325,000	12,400	159
1970	326,500	314,200	12,300	156
Projected				
2010	788,700	735,300	53,400	278
2000	708,600	667,600	41,000	264
1990	597,000	569,200	27,800	239

(Data are based on reporting by physicians and medical schools.)

NOTES: The population includes U.S. residents in the 50 States, District of Columbia, and civilians in Puerto Rico, other U.S. outlying areas and the Armed Forces abroad. The number of M.D.'s differ from American Medical Association figures because a variant proportion of the physicians not classified by activity status and whose addresses are unknown are allocated into the totals.

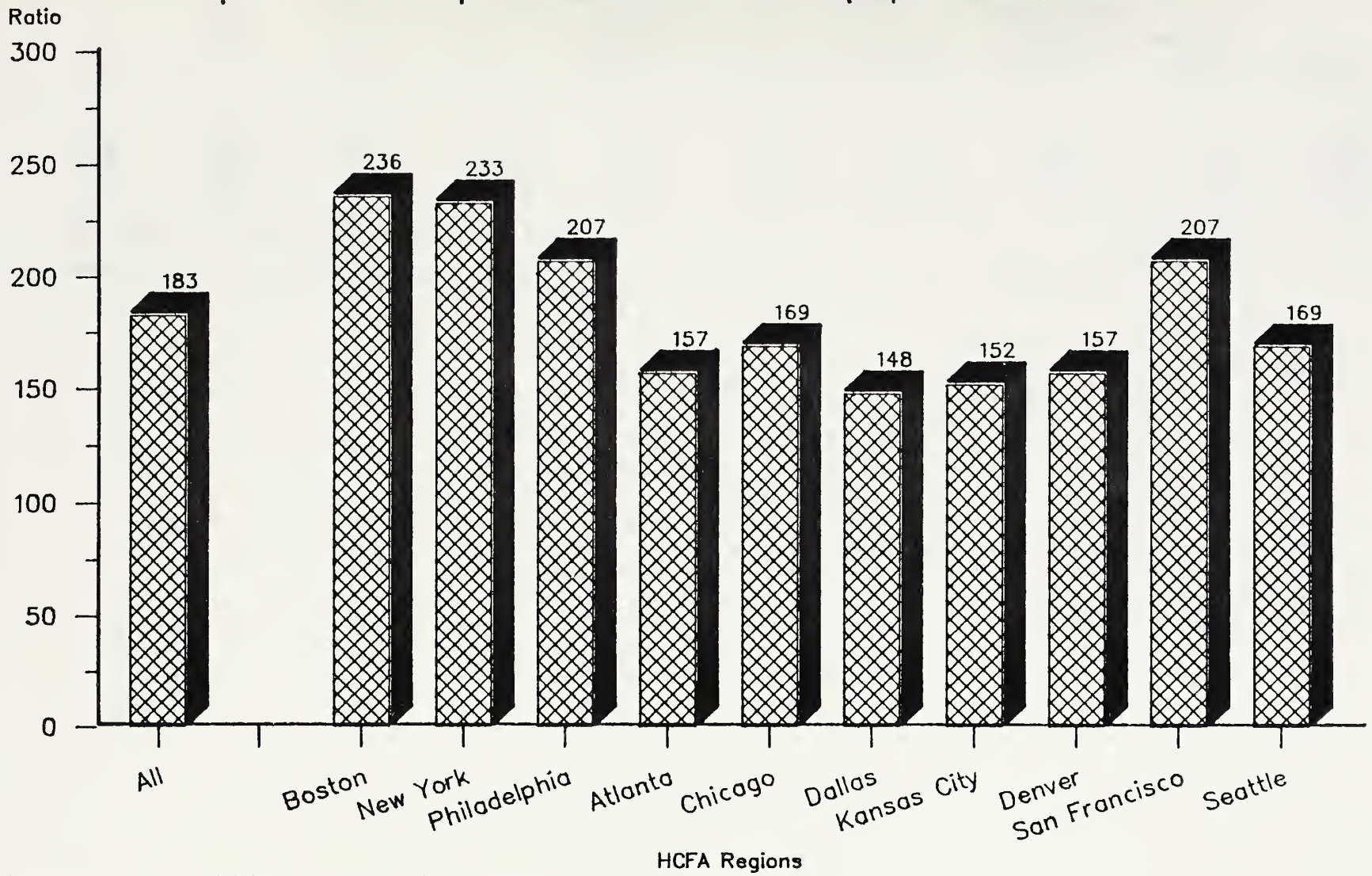
SOURCE: HRSA/Bureau of Health Professions and Bureau of the Census.

Table 2
Ratio of non-Federal physicians involved in patient care per 100,000 civilian population: 1986

HCFA regions	Ratio	Index
All regions	183	1.00
Boston	236	1.29
New York	233	1.27
Philadelphia	207	1.13
Atlanta	157	0.86
Chicago	169	0.92
Dallas	148	0.81
Kansas City	152	0.83
Denver	157	0.86
San Francisco	207	1.13
Seattle	169	0.92

SOURCE: American Medical Association

Figure 1
Ratio of non-Federal physicians, involved in patient care per 100,000 civilian population, 1986



Prepared by the Division of Information Analysis

Table 3
Physician income and expenses

Year	Mean net income 1/	Mean expenses: Mean	Total	Non-physician payroll	Office	Medical supplies	Professional liability expenses	Medical equipment	Other
			Percentage distribution						
1987	132.3	123.7	100.0	34.4	24.3	10.9	12.1	5.3	13.1
1986	119.5	118.4	100.0	32.8	24.1	10.8	10.8	5.9	15.3
1985	112.2	102.7	100.0	34.7	25.7	10.9	10.2	5.7	12.8
1984	108.4	94.0	100.0	33.2	26.0	11.4	8.9	5.9	14.7
1983	$104.1	$85.4	100.0	34.0	24.8	10.9	8.1	6.0	16.3

1/ After expenses, before taxes.

SOURCE: Socioeconomic Characteristics of Medical Practice, American Medical Association.

Table 4
Physician income and expenses by selected specialties: 1987

	Mean net income 1/	Mean expenses							
		Mean	Total	Non-physician payroll	Office	Medical supplies	Professional liability expenses	Medical equipment	Other
	(thous.)	(thous.)	Percentage distribution						
All physicians	$132.3	$123.7	100.0	34.4	24.3	10.9	12.1	5.3	13.1
Specialty									
General/Family Practice	91.5	121.2	100.0	35.1	24.8	14.2	7.3	5.9	12.6
Internal medicine	121.8	117.8	100.0	37.1	24.4	14.3	7.1	4.3	12.8
Surgery	187.9	164.7	100.0	35.4	23.2	8.4	14.9	5.6	12.6
Pediatrics	85.3	100.2	100.0	33.6	31.0	16.6	7.1	4.1	7.6
Obstertrics/gynecology	163.2	173.2	100.0	27.8	24.7	10.0	20.4	4.9	12.2

1/ After expenses, before taxes.

SOURCE: Socioeconomic Characteristics of Medical Practice, American Medical Association.

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